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ABSTRACT

The document presents the final report of a comparative study to assess the services being provided to handicapped preschool children by Project Head Start and non-Head Start programs. This study is Phase I of a larger study of the process of mainstreaming handicapped children in Head Start programs. To facilitate an understanding of Phase I findings and recommendations, the first part of the report presents background information, including study methodology and the context in which service delivery to handicapped children in Head Start programs is taking place. Study findings are discussed for the following areas of investigation: mainstreaming, staff characteristics, program entry and termination, screening services, diagnostic services, planning and curricula, monitoring activities, service providers, and parent involvement. Four basic areas are recommended in which Head Start services to handicapped children can be improved: diagnostic services, program services (particularly with respect to individualized planning), program facilities and materials, and outreach procedures to seek out unserved handicapped children. (DLS)

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EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO PROJECT HEAD START

Phase I Final Report

May 19, 1978

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PART 1

BACKGROUND OF THE STUDY

To facilitate the reader's understanding of the study findings and recommendations, the first part of the report presents background information to the study. Chapter 1, Introduction, briefly describes the historical, legal, and philosophical context in which service delivery to handicapped children in Head Start programs is taking place; further, Head Start's involvement in the education of handicapped children over the past several years is traced. Finally, the major purposes of the study are outlined. Chapter 2, Study Methodology, describes the strategy used to conduct the study. That is, sampling procedures, instrument development, and data collection and analysis techniques are briefly delineated, and the samples of Head Start and non-Head Start programs and Head Start handicapped children are described.

1

INTRODUCTION

Within a relatively short period of time, there has been an almost complete reversal in the approach to the education of the handicapped. Once relegated to segregated special classes for the duration of their schooling, handicapped children and youth were often doomed to an isolated existence. They were seen as "different" or "special" and were not allowed potential benefits of close association with their non-handicapped peers. Some critics charged that special education classes served as "dumping grounds" for troublesome or culturally different children, and that, once placed in special classes, these children were not provided with appropriate services.

Today, a new approach to educating handicapped children is rapidly replacing this old model of segregated education. Mainstreaming - serving and educating handicapped children in the same setting with normal children to the maximum extent possible - is the cornerstone of the new approach. This practice is based on the philosophy that handicapped children are more similar to normal children than they are different, and that both groups will benefit from close association with each other. However, simply placing handicapped children in physical proximity to normal children is only one component of the new special education approach. To accompany and support the practice of mainstreaming, more comprehensive and sound assessment procedures have been introduced to avoid mislabeling of children. There has been a new emphasis on providing each handicapped child with individualized services appropriate to his/her unique needs. Further, educational programs serving handicapped children have increased their efforts to train their staff to appropriately serve handicapped children and have attempted to involve the parents of these children in their children's assessments, placement, program planning, and service delivery processes.

This trend toward the integration of handicapped children and youth into regular school programs has greatly accelerated as officials of the courts, educators, and laymen have become aware of the need to achieve educational equality as well as quality education. Yet it is because of this rapid change in practice that the basic research necessary to support and direct the movement towards comprehensive service delivery to handicapped children in a mainstream setting has lagged conspicuously behind theoretical advances. It is hoped that this study, funded by the Administration for Children, Youth, and Families to evaluate the process of mainstreaming handicapped children into Project Head Start, will at least be a preliminary step toward filling this void as well as providing the groundwork for further improvements in education for the handicapped.

Historical Perspective

The impetus for mainstreaming can be traced back to the early 1930's. In 1932, Bennett expressed concern over the placement of mentally retarded children in special, self-contained classrooms. He found that retarded children in regular classes performed better than their counterparts in special education classes.[1] Pertsch came to the same conclusions in 1936.[2] Nevertheless, these concerns over the segregation of handicapped children went largely unnoticed.

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[1] A. Bennett, A Comparative Study of Subnormal Children in the Elementary Grades (New York: Teachers College, Columbia University, 1932).

[2] C. F. Pertsch, A Comparative Study of Subnormal Pupils in the Grades and in Special Classes (New York: Teachers College, Columbia University, 1936.

By 1962, the concept of mainstreaming was still a radical one and separate special education classes were the accepted practice. However, after reviewing 14 studies, Johnson concluded that while there was no support for integrated classes, neither was there support in favor of placement in special classes. He wrote:

> It is indeed paradoxical that mentally handicapped children having teachers especially trained, having more money (per capita) spent on their education, and being enrolled in classes with fewer children and a program designed to provide for their unique needs should be accomplishing the objectives of their education at the same or at a lower level than similar mentally handicapped children who have not had these advantages and have been forced to remain in the regular grades.[1]

While Johnson's article stirred a great many debates on the issue, in practice very few actual changes in the traditional system ensued. It was not until 1968, when Lloyd Dunn published his now landmark essay, that the educational community began to widely embrace the idea of mainstreaming. In this article, Dunn questioned the integrity of special classes as the model for serving mentally retarded children. He called upon educators to "... stop being pressured into a continuing and expanding special education program that we know now to be undesirable for many of the children we are dedicated to serve."[2] The respect which Dunn carried in the educational community coupled with the social climate of the day was influential in making educators receptive to the mainstreaming thesis. His impact upon the approach to special education was monumental, as MacMillan acknowledges: "Clearly, Dunn has been the important influence in reversing a trend toward the proliferation of self-contained special classes."[3]

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[1] G. Orville Johnson, "Special Education for the Mentally Handicapped," Exceptional Children, (29, 1962) p.66.

[2] Lloyd M. Dunn, "Special Education for the Mildly Retarded - Is Much of It Justified?" Exceptional Children (35, 1968) p.5.

[3] Donald L. MacMillan, "Special Education for the Mentally Retarded: Servant or Savant," Focus on Exceptional Children (2, 1971), p.1.

As the educational community began to support the practice of mainstreaming, several other related developments occurred. Parents of minority children and minority leaders began to protest the classification of proportionately large numbers of their children as handicapped and they suggested that at least some of these children were mislabeled. This action led, in part, to widespread questioning of the accuracy and fairness of psychological tests and prevalent assessment procedures. Subsequent revisions in available tests and assessment procedures have since occurred. Secondly, support grew for the notion that each handicapped child needs to be provided with an individualized plan of services appropriate to his/her specific needs, and that the handicapping condition alone cannot be the primary determinant of appropriate services. Parents have become more vocal about representing the interests of their children and have demanded - and received - participation in decisions related to their children's assessment, classification, placement and service delivery. All of these factors combined to influence a change in the basic educational philosophy towards education for handicapped children in a mainstream setting.

Concommitant with the educational thrust toward mainstreaming were legal and economic incentives for its adoption. By 1974, over 36 cases had already appeared before the State and Federal courts which were decided in favor of guaranteeing a handicapped child the full right to education by applying the doctrine of least restrictive alternatives. That is, children with handicaps cannot unquestioningly be placed in institutions, segregated classes, or other restricted environments. Instead, to the maximum extent that his/her ability allows, a handicapped child must be placed in an educational setting with non-handicapped children. On the other hand, the doctrine of least restrictive alternates does not suggest that each handicapped child should be placed in a totally mainstreamed (integrated) setting, regardless of the severity of the handicap and/or the child's ability to optimally function in a setting with non-handicapped children. Rather, a continuum of placement settings should be available, from fully mainstreamed to fully segregated, and a child's unique needs and abilities should determine the appropriate placement, instead of the handicapping "label."

The decisions in favor of least restrictive alternatives were based on the assumption that placement of a child in a segregated educational environment may be a restriction of fundamental liberties. If special educational placement is deemed necessary, this must be done using the "least restrictive alternative" available. In all, over half of the States have enacted legislation aimed at educating exceptional children "... as a part of rather than apart from ..." their non-handicapped peers.[1/] Furthermore, recent federal legislation now requires that all handicapped children educated by the State must be placed in the least restrictive setting possible.[2/]

In addition to the legal impetus given to the mainstreaming movement, the financial policies prevalent in a great many States have also influenced the acceptance of mainstreaming. For example, States such as Georgia and Texas have encouraged the adoption of mainstreaming since the State laws permit the inclusion of handicapped children in program funding formulae if they are mainstreamed, but not if they are in segregated classes.[3/] Similarly, Florida uses a weighted equivalency formula for fund allocation which favors the process of mainstreaming.

As the acceptance and popularity of mainstreaming have grown, the concept itself has developed in complexity. The amount of time spent in a mainstreamed environment and the existence or nonexistence of supportive personnel have become important variables

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[1/] Gary W. Nix, Mainstreaming for Hearing Impaired Children and Youth (New York: Grune and Stratton, 1976), p.1.

[2/] P.L. 94-142.

[3/] Georgia Board of Education and State Superintendent of Schools, Policies and Executive Procedures, Atlanta, Georgia. n.d.

in determining the degree and type of mainstreaming available. Bitter and McGee have outlined eight approaches to mainstreaming:[1]

Type I: Complete mainstreaming of the student in his or her neighborhood school without supportive help from a specialist.

Type II: Full mainstreaming of the student in his or her neighborhood school with supportive instruction from a special education teacher or other kind of specialist.

Type III: Partial mainstreaming of the student who is based in a special resource room and attends some general education classes.

Type IV: Team teaching arrangements in which general education teachers and special education teachers cooperatively teach all students in a general education setting.

Type V: Reverse mainstreaming in which normal students become part of a special education class. This type is most prevalent at the preschool level.

Type VI: Self-contained classes from which students go to general education classes for instruction in one or more academic subjects.

Type VII: Self-contained classes from which students go to general education classes to participate in one or more nonacademic activities.

Type VIII: Completely self-contained classes in which children have occasional contact with nonhandicapped peers.

The Involvement of Project Head Start in Mainstreaming

Project Head Start has been at the forefront of the mainstreaming movement since the first years of its inception. Head Start is a comprehensive developmental program for economically disadvantaged preschool children, designed to provide children with the opportunity to develop their full potential. Head Start is based on the philosophy that:

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[1] Donald J. McGee, "Mainstreaming Problems and Procedures: Ages 6-12," p. 137; and Grant B. Bitter, "Whose Schools: Educational Expediency/Educational Integrity?" p. 12, in Models for Mainstreaming, Keith Barry (ed.) (San Rafael: Dimensions Publishing, 1972.)

- a child can benefit most from a comprehensive inter-disciplinary attack on his problems at the local level; and
- the child's entire family, as well as the community, must be involved in solving these problems.

The overall goal of the Head Start program is to bring about a greater degree of social competence in children of low income families.

Since Head Start's official beginning under the Office of Economic Opportunity in May of 1965, more than 5-1/2 million children have been enrolled in Head Start. Currently, more than 1,600 grantees across the nation in over 9,400 centers are serving approximately 350,000 children, including the handicapped.

Project Head Start has always had a policy of open enrollment for all eligible children regardless of special needs. As early as 1967, Head Start had identified the need for providing all children with a comprehensive developmental program and encouraged the enrollment and mainstreaming of handicapped children. As the 1967 Head Start Manual states: "Head Start encourages the inclusion of mentally and physically handicapped children in an integrated setting with other Head Start children."

Five years later, the 1972 Amendments to the Economic Opportunity Act further stipulated a national minimum of 10 percent handicapped enrollment for Head Start Programs and that relevant services be provided: "not less than 10 per centum of the total number of enrollment opportunities in the nation in the Head Start program shall be available for handicapped children and that services shall be provided to meet their special needs."[1] The legislation went on to define handicapped children as "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who by reason thereof require special education and related services."

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[1] P.L. 92-424.

In response to this mandate the Office of Child Development (now the Administration for Children, Youth and Families) redoubled its efforts to identify, enroll and serve handicapped children. Policy guidelines were established (OCD Notice N-30-333-1) to aid in the implementation of this mandate and to set forth the requirements applicable to each Head Start grantee. The Head Start, Economic Opportunity, and Community Partnership Act of 1974 further strengthened Head Start's affirmative outreach and recruitment program by requiring that the 10 percent enrollment mandate be met at the State level. The intent of this mandate was three-fold:

- to ensure that handicapped children were served in a mainstream environment or an integrated setting:
- to provide for the special needs of handicapped children; and
- to promote and encourage an inter-relationship between Head Start and other agencies serving handicapped children.

That mainstreaming can be mutually beneficial to both handicapped and non-handicapped children is now a widely accepted viewpoint. Yet in spite of the recent attention this concept has received, there have been few research studies or evaluations to support and direct movement towards comprehensive service delivery to handicapped children in a mainstream setting. Furthermore, there have been no large-scale studies to assess the impact of Head Start services on handicapped and normal Head Start children. To address these research needs, the Office of Child Development funded a study entitled "Evaluation of the Process of Mainstreaming Handicapped Children into Head Start," consisting of two phases over a two-year period. The purpose of the first phase of this study, the subject of this report, was to:

- describe the services provided to handicapped children in Project Head Start Programs; and

- assess the services being provided to similar children enrolled in programs other than Head Start.

The focus of Phase I, then, was to describe the continuum of services that Head Start and non-Head Start programs provide to handicapped children. The Head Start descriptions are based on a sample of 269 handicapped children representing 10 basic handicapping conditions,[1] who were enrolled in 59 Head Start programs during the 1976-77 school year. Data collected on these children were largely child-specific. The non-Head Start program data were program-specific and were based on a sample of 46 programs serving pre-school handicapped children in the same communities as the Head Start programs.[2]

The study collected data on a wide variety of services that preschool programs provide to handicapped children. In essence, the study examined the continuum of services that a handicapped child could expect to receive during a program year, ranging from screening and diagnosis to the provision of specialized services. In addition, the services that are provided to the program staff and parents to facilitate service delivery to children were also investigated. The following discussion briefly summarizes the content of the study.

The procedures that programs use to enroll handicapped children, including outreach and child find activities, are described in the chapter on Program Entry. This chapter also describes the types of children who were identified and not enrolled and the reasons for their non-enrollment, as well as the conditions related to termination of children from Head Start programs.

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[1] The study used the ten categories of handicapping conditions defined by the Administration for Children, Youth and Families: visual impairment, blind, hearing impairment, deaf, physical handicap, speech impairment, health or developmental impairment, mental retardation, specific learning disability, and serious emotional disturbance.

[2] The sample characteristics and sampling procedures are fully described in Chapter 2, "Study Methodology and Sample Characteristics."

The Screening chapter describes the process that programs use to identify children with potential handicaps for a more in-depth evaluation, including the time of occurrence of screening, professionals who conduct screening, techniques used, involvement of parents, and relationship to the diagnostic effort. Subsequently, the processes used to confirm, functionally assess, and develop recommendations for children with suspected handicaps is described in the Diagnosis chapter. This chapter considers the type of techniques and professionals used for diagnosis, the completeness of the process, the involvement of parents, and the utilization of diagnostic results.

The Mainstreaming chapter describes the program settings in which handicapped children were placed and the extent to which handicapped children were integrated with their normal peers. Further, the chapter on Planning and Curricula describes how classroom activities were planned and implemented for handicapped children, and the types of individualized plans of service that were developed for these children. The chapter on Monitoring describes the process by which the services provided to a child were periodically evaluated in relation to the child's response to these services and subsequently modified as necessary.

Several chapters relate to the training provided to staff and parents and the type of professionals, within and external to the program, who provide services to the children. The Staff Characteristics chapter describes the staffing structure of Head Start and non-Head Start programs, and the training and technical assistance provided to the staff of Head Start and non-Head Start programs. The chapter on Parent Involvement describes the type of program activities in which parents of handicapped children participated and the extent of their involvement. Finally, the Service Providers chapter describes the type of professionals, external to the program staff, who provided services to handicapped children and the types of activities in which they were involved.

As the previous discussion indicated, Phase I is a descriptive study. No attempt was made to evaluate the appropriateness or quality of the services delivered to handicapped children, the accuracy of screening and diagnoses, etc. However, whereas Phase I addresses the issue of "what is being done" for handicapped children in Head Start and non-Head Start programs, Phase II will focus on issues related to the *impact* of these services on the growth and development of handicapped pre-school children. Extensive child assessments, examinations of parents and teacher attitudes as well as information concerning parent, child and program characteristics will comprise the Phase II data collected in 1977-78.

2

STUDY METHODOLOGY AND SAMPLE CHARACTERISTICS

STUDY METHODOLOGY

In order to obtain an appropriate data base to answer basic study questions, data were collected to characterize services generally provided to handicapped children by a nationally representative group of Head Start programs and the specific services received by handicapped children enrolled in these programs. Data were also collected to contrast the services provided to handicapped children by Head Start programs with the services provided to handicapped children by non-Head Start preschool programs. In brief, the subjects of the study were a sample of 59 Head Start programs and a sample of 269 handicapped children enrolled in these programs, as well as a sample of 46 non-Head Start preschool programs that provided services to handicapped children. Both program-specific and child-specific data were collected on the Head Start programs, while only program-specific data were collected on the non-Head Start programs. Respondents consisted primarily of the program staff and specialists who provided services to the handicapped children. Limited program and child data were also collected through observation and from secondary data sources.

The sections that follow describe the major components of the study's methodological approach, including:

- design and implementation of sampling strategies
- instrumentation

- data collection procedures
- data analysis techniques

Finally, the characteristics of the sample Head Start and non-Head Start programs and handicapped children are outlined.

Head Start Program Sample

The sample of Head Start programs was selected from the universe of approximately 1,600 full year grantees or delegate agencies[1/] funded as of September 30, 1976. Grantees were stratified on the basis of the following two variables:

- urban/rural location[2/]
- program enrollment (1-200, 201-400, 401-1000, over 1000)

Following assignment of the universe of grantees to one of eight possible cells,[3/] 55 programs were randomly selected in proportion to their representation within these cells. An additional five programs were then randomly selected from a roster of Indian and migrant programs, yielding a total sample of 60 Head Start programs. However, data were only collected from 59 programs. At the time of data collection completion (June, 1977), one program had not yet identified any handicapped children and was excluded from the study.[4/]

[1/] If a grantee funded a delegate agency, the grantee was included in the universe only if it operated a program independently of the delegate. Otherwise, only delegate agencies were considered for inclusion in the study universe.

[2/] A program was considered to be an urban program if it was located within a Standard Metropolitan Statistical Area (SMSA) as defined by the Bureau of the Census. Generally, an SMSA is comprised of a central city and contiguous ring counties. Programs located outside of SMSAs were considered to be rural.

[3/] Each sample cell represented a unique combination of program size and program location.

[4/] The program excluded was a migrant program that had not yet begun operations in time for field staff to collect meaningful information concerning handicapped services.

Non-Head Start Program Sample

Non-Head Start programs were chosen from the same communities in which the selected Head Start programs were located. Potential study participants were identified through a number of sources. The director of each selected Head Start program was asked to provide names, addresses and telephone numbers of programs in his/her area that provided services to preschool handicapped children. Other resources contacted for the same purposes included State Departments of Education, local school systems, local Public Health Departments, and State and local directors of Easter Seal agencies and the Associations for Retarded Children.

Approximately 180 non-Head Start programs were identified through these sources, and each identified program was contacted to explain the purpose of the proposed study and to solicit their participation. A total of 104 programs agreed to participate. From this group of programs, one non-Head Start program was selected randomly for each Head Start program. However, fourteen (14) Head Start programs had no non-Head Start preschool programs in their communities or had no other programs that were willing to participate.[1/] Therefore, a final sample of forty-six (46) non-Head Start programs was obtained.

Head Start Student Sample

As initially conceived, the sample of Head Start children for the Phase I study was to include 280 individuals, 35 from each of the following handicapped classifications:

- Visually Impaired or Blind
- Hearing Impaired or Deaf
- Physically Handicapped

[1/] There were eight communities with no existing alternative preschool programs serving handicapped children and six communities in which preschool programs were unwilling to participate in the Phase I study.

- Speech Impaired
- Health or Developmentally Impaired
- Mentally Retarded
- Seriously Emotionally Disturbed
- Specific Learning Disabilities

Each selected Head Start program was to forward a coded roster of its handicapped enrollees. This roster was to also indicate the enrollee's primary handicapping condition. As lists were received, three children from each were to be selected at random and assigned to their respective classification. The balance of the children on these rosters was to be pooled according to primary handicap regardless of program affiliation. A determination was then to be made of the total sample per handicap obtained after selection of three children from each of the programs. The children to make up the difference between these totals and the total of 35 required per condition were to be selected randomly from the balance of the program rosters.

However, Head Start programs did not compile their coded rosters as quickly as expected, and field activities were begun before all rosters were obtained. Therefore, children were systematically selected from rosters as soon as they were obtained. Although random selection of the study sample was not possible, it should be noted that all children were selected based only on the information provided on the coded rosters. Systematic selection was required in order to ensure that to the extent possible, 35 children were represented in each of the handicapping classifications indicated.

After potential sample participants were identified from the coded rosters, the Head Start programs were informed of the selections and asked to secure informed, written parental permission to allow children to be included in the study. Parents were overwhelmingly cooperative in this manner, although the final sample had to be modified in a few instances to accommodate parental requests not to have their children participate.

The limitations of the Phase I sample should be clearly understood. While Head Start programs were randomly chosen, individual children were not. Consequently, inference from the study sample to the larger universe of handicapped enrollees in Head Start must be approached cautiously. However, there is no reason to suspect the overall representativeness of the enrollee sample, and to that extent the findings and conclusions presented in this study must be assumed to validly reflect current efforts by Head Start to meet the needs of the handicapped.

Instrumentation and Data Collection Procedures

Instrumentation for the Phase I study was developed in conjunction with staff from ACYF. All data collection schedules were developed specifically for this study with the exception of one instrument that made use of selected items from the Fifth Annual Survey of Head Start Handicapped Efforts.

In total, 10 different schedules were developed. Exhibit 2.1 summarizes the respondents, purposes and methods of administration for each of these instruments. The entire instrument package is presented in Appendix B.

All data were collected by a trained staff of 14 field interviewers between April 1, 1977 and June 10, 1977. Interviewers were selected primarily on the basis of previous experience in large scale data collection efforts, although experience and/or academic training related to special education or early childhood development was also considered.

Interviewers generally operated in teams of two, although sometimes in the case of smaller programs, only one interviewer was utilized. Teams spent from two to five days in each of the 59 communities visited depending on the number of children sampled from the Head Start programs in question.

EXHIBIT 2.1: STUDY INSTRUMENTATION

Focus	Instrument	Purpose	Source	Method
Program-Specific Data on Head Start Programs	Primary Data Interview Schedule	Describe enrollment and termination procedures and types of handicapped children enrolled	Head Start Director	Mailed questionnaire or personal interview
	Facilities Walk-Through Checklist, Section A	Describe facilities and equipment in the Head Start centers	Head Start Centers	Observation
	Secondary Data Instrument	Determine program demographic character characteristics	Fifth Annual Survey	Transcribe data
	Non-Enrolled Child Interview Schedule	Describe handicapped children not enrolled in the programs	Parents	Telephone or personal interview
Child-Specific Data for Sample Handicapped Children	In-Depth Case Study Schedule	Describe services provided to the child	Program staff	Personal interview
	Facilities Walk-Through Checklist, Section B	Determine extent of social integration of child in the classroom	Child in classroom setting	Observation
	Service Provider Schedule	Describe characteristics of child's service providers and types of services provided	Service providers	Telephone or personal interview
	Written Record Review	Analyze child's diagnostic file	Diagnostic file	Questionnaire
Program-Specific Data on non-Head Start programs	Alternate Program Schedule	Determine program characteristics and services typically provided to handicapped children	Program Director	Personal interview
	Facilities Walk-Through Checklist, Section A	Describe program's facilities and equipment	Program building and classrooms	Observation

Data Analysis Procedures

As they were completed, questionnaires were returned to Applied Management Sciences where they were manually edited and checked for consistency, missing data, and clarity of responses. This initial editing process permitted resolution of errors while interviewers were still in the field. Additionally, all open-ended responses were categorized and coded. Edited and coded questionnaires were keypunched and the data were entered onto magnetic tape. Following the establishment of a clean data base through machine editing, data analyses were conducted to address basic study questions.

The analytic procedures were intended to provide a perspective on the "state-of-the-art" of the services made available to handicapped children in Head Start and non-Head Start preschool programs. As such, data analysis was descriptive and consisted of:

- Univariate Frequency Distributions: Certain variables required to analyze services received by handicapped children were evaluated in terms of the relative frequency with which they were encountered in the study sample. For example, the number of children screened prior to enrollment in Head Start, and the number of children in each handicapping area for which a functional assessment was completed, were usefully analyzed, in part, by this simple descriptive technique.
- Bivariate Frequency Distributions: Commonly referred to as contingency tables or "cross-tabs," bivariate frequency distributions provided information concerning the relationship of one variable with another. While a relatively simple analytical technique, contingency tables were very useful for developing descriptive statistical profiles. In addition, data contained in these tables are easily communicated to a wide audience. Measures of association such as Chi Square were occasionally used to interpret the significance of certain bivariate relationships. However, in most analyses the importance of association was considered to be a function of policy implication rather than statistical significance.

Tabulations were produced from the data file using the Statistical Package for the Social Sciences (SPSS), TPL, and PROTABS.[1]

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[1] TPL is the Table Production Language software package; PROTABS is proprietary software of Applied Management Sciences, Inc.

SAMPLE CHARACTERISTICS

Based on the selection procedures discussed in the preceding section, the final sample from which Phase I results were derived included 59 Head Start programs, 46 non-Head Start programs and 269 Head Start children. Below is a brief description of the primary characteristics of each of these sample components.

Head Start Programs

Of the 59 Head Start programs participating in the Phase I study, 35 were located in rural areas and 24 were located in urban areas. At least one program was selected from each of the 10 DHEW Regions with the exception of Region X (Idaho, Washington, Oregon and Alaska). Sixteen of the programs were located in Region IV (North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Kentucky and Tennessee). In terms of their distribution among the four U.S. Census Regions, (North East, North Central, South and West) the sample of Head Start programs matched almost exactly the universe of all Head Start programs (Table 2.1).

TABLE 2.1

Distribution of Head Start Sample Programs by U.S. Bureau of the Census Regions

Region		Distribution of Head Start Programs	
		Universe %	Sample %
I	Northeast	20.3 (N=332)	17.0 (N=10)
II	North Central	25.2 (N=411)	25.4 (N=15)
III	South	35.6 (N=579	40.6 (N=24)
IV	West	18.9 (N=310)	17.0 (N=10)
	Total	100.0 (N=1632)	100.0 (N=59)

Eleven of the sample programs reported total enrollments of at least 200 children, 18 reported enrollments between 200 and 400 children, 11 between 400 and 1,000, and 15 programs reported enrollments in excess of 1,000 children.[1]

Non-Head Start Programs

Of the 46 non-Head Start programs participating in the Phase I study, 24 were located in rural areas and 22 were located in urban areas. Proportionately, then, the non-Head Start program sample was more urban in character than the Head Start program sample, although only by a slight degree (47.8% vs 40.7%, respectively). Non-Head Start programs were also much smaller in terms of total enrollments. This was due to the fact that 36 of the 46 non-Head Start programs primarily or exclusively served handicapped children. Only four non-Head Start programs had enrollments in excess of 100 children and these were preschool programs associated with public school systems. In addition, almost half of the non-Head Start programs were categorical; that is, they served children with one basic type of handicap (generally mentally retarded or physically handicapped children).

It is important that these differences between Head Start and non-Head Start programs are noted, because these differences clearly indicate that Head Start is a relatively unique preschool program that has few, if any, counterparts to which it can be directly compared. This point should be kept in mind when data are presented concerning the non-Head Start study sample.

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[1] Enrollment data were not provided for four programs.

Handicapped Children in Head Start

As previously indicated, it was intended that the Phase I study sample include 35 children for each of the eight[1/] basic handicapping conditions, yielding a total sample of 280 children. Because the original sampling strategy could not be implemented for the reasons cited, the actual study sample included 269 children. As Table 2.2 indicates, the number of children obtained by handicapping condition did not result in 35 per category. However, with the exception of the blind/visually impaired and the deaf/hearing impaired categories (21 and 23 children, respectively), the distribution of handicaps among the study sample reasonably approached the intended limit of 35 per condition. Fifty-nine speech impaired children were also selected, but this reflects the extremely large proportion of all handicaps served by Head Start that involve speech disorders (over 47% of all reported handicaps).

In terms of handicap severity, Table 2.3 indicates that over 40 percent of the children were classified as moderately handicapped. Another 23 percent were designated as mildly handicapped, and almost 30 percent were considered severely or profoundly handicapped.[2/]

[1/] Blind and visually impaired and deaf and hearing impaired were collapsed into single categories, respectively.

[2/] Determination of severity was made by Head Start staff. If doubt existed, field staff presented respondents with a set of criteria cards to assist in this determination.

TABLE 2.2

Distribution of Head Start Children According to Handicapping Conditions[1]

Primary Handicapping Condition	% of Total
Visually Impaired	5.6 (N=15)
Blind	2.2 (N=6)
Hearing Impaired	7.8 (N=21)
Deaf	0.7 (N=2)
Physical Handicap	13.8 (N=37)
Speech Impaired	21.9 (N=59)
Health or Developmentally Impaired	11.2 (N=30)
Mentally Retarded	13.0 (N=35)
Specific Learning Disability	11.5 (N=31)
Serious Emotional Disturbance	12.3 (N=33)
Total**	100 (N=269)

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[1] These data are specific to the Phase I study and do not reflect the actual distribution of the types of handicaps served by Head Start nationally.

TABLE 2.3

Distribution of Head Start Children According to Severity Level of Handicap

Severity Level of Primary Handicap[1]	% of Total
Mild	22.7 (N=61)
Moderate	41.3 (N=111)
Severe	27.1 (N=73)
Profound	2.6 (N=7)
Not Relevant[2]	3.0 (N=8)
No Response	3.3 (N=9)
Total**	100.00 (N=269)

[1] Criteria for establishing severity of handicap are presented in Appendix C.

[2] Includes 6 children who were blind and 2 children who were deaf.

PART II

STUDY FINDINGS

Part II is divided into nine separate chapters, each of which presents the major study issues, a detailed statement of findings, and summary of findings related to an individual topic. Following an initial chapter describing program settings, the chapters are organized in the approximate chronological order in terms of the services that a handicapped child is expected to receive in a preschool environment. The chapters are:

3. Mainstreaming: Context and Process
4. Staff Characteristics
5. Program Entry and Termination
6. Screening Services
7. Diagnostic Services
8. Planning and Curricula
9. Monitoring Activities
10. Service Providers
11. Parent Involvement

The reader must be aware of several characteristics of the data base to properly interpret and analyze the findings. Most importantly, the unit of analysis varies according to the question under consideration. The majority of Head Start data are based on individual handicapped children and are *child-specific*. Some of the Head Start data, however, pertain to characteristics of the individual programs and are *program-specific*. In contrast, almost all of the non-Head Start data are based on program-level information and are *program-specific*. Direct comparisons cannot be validly made between child-specific Head Start data and program-specific non-Head Start data. Only general similarities or dissimilarities in trends can be noted. Finally, for both Head Start and non-Head Start programs, some data are based on the number of staff in the program or the number of staff that served specific children. In these cases, data are *staff-specific*. The relevant unit of analysis is noted throughout the text in all Part II Chapters.

Other charactersistics of the data make it difficult to compare Head Start and non-Head Start findings, especially in cases where the Head Start findings are based on child-specific data and non-Head Start findings are based on program-specific data. In many cases, the same question was asked of program staff but the response options appropriate for Head Start children vs. non-Head Start programs were different. Specifically, non-Head Start programs often had the options to select as many responses as applied with respect to a given question. Head Start staff, on the other hand, may have had to respond only in reference to a given child, even though other responses might have been selected had the program been the unit of analysis. Again, this problem is noted at appropriate points in the text.

For the most part, data are presented in tabular form within the text, although some tables are appended to the report. Both raw figures and either row or column percentages are included in the text. Rows or columns that do not total to exactly 100.0 percent due to rounding error are marked by a double asterisk (**).

3

MAINSTREAMING: CONTEXT AND PROCESS

As indicated in the introduction to this report, mainstreaming generally refers to a service delivery system that provides for the inclusion of handicapped children in an integrated setting with their non-handicapped peers. Mainstreaming is the cornerstone on which Project Head Start has based its services to preschool handicapped children. Although it is a widely endorsed practice for structuring the setting in which special children are served, few programs, public or private, have attempted to implement a mainstreaming strategy to the extent to which Head Start has.

It is appropriate, therefore, that the first substantive chapter of this report focuses upon the mainstreaming of handicapped children in Head Start. Specifically, data were collected and analyzed relating to the following issues:

- What types of mainstreaming options were implemented in Head Start classes?
- Does the degree of mainstreaming vary as a function of the nature and severity of a child's handicap?
- What proportion of time did the handicapped children spend in a mainstreaming context?
- To what extent were handicapped children socially integrated into their respective classes?
- Have Head Start programs acquired, or developed, the appropriate facilities and materials to meet the needs of their handicapped enrollees?

When appropriate, data concerning these same issues are also presented for the non-Head Start programs visited in the course of this study.

Mainstreaming Options

Whatever else is implied by the concept of mainstreaming, the basic goal of this approach to serving handicapped children is to provide a social experience with non-handicapped peers. Such an experience is believed to reduce the negative effects of segregated classrooms on the social, emotional, and cognitive development of the handicapped child. In brief, a mainstreaming experience is designed to increase a handicapped child's competence in adjusting and coping with his/her disability in a society whose social and economic institutions are decidedly oriented toward individuals without physical and/or mental impairment.

As discussed in Chapter 1, a child may receive a mainstreaming experience under a variety of conditions. Six such mainstreaming options were distilled from those outlined by McGee and Bitter[1] for investigation in this study. These six options are as follows:

- complete mainstreaming of handicapped child into a regular classroom (no supportive assistance);
- complete mainstreaming of handicapped child into a regular classroom with supportive assistance provided by a specialist;
- complete mainstreaming of handicapped children in a classroom where the regular classroom teacher and a special education teacher cooperatively work with all children (a team arrangement);
- reverse mainstreaming in which normal children become part of a special education class;
- partial mainstreaming where handicapped children are in a special education class but go to mainstreamed classes for one or more regular classroom activities; or
- handicapped children receive services from the program but are not mainstreamed.

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[1] Donald J. McGee, "Mainstreaming Problems and Procedures: Ages 6-12," p. 137; and Grant B. Bitter, "Whose Schools: Educational Expediency/ Educational Integrity?" p. 12, in Models for Mainstreaming, Keith Barry (ed.) (San Rafael: Dimensions Publishing, 1972.)

Data in Table 3.1 indicate the types of mainstreaming placements afforded the 269 children included in this study.

As is readily apparent, the majority of all the Head Start children included in the study sample (92.6%) were completely mainstreamed. Moreover, 54 percent were involved in complete mainstreaming situations in which educational and/or therapeutic services were augmented by specialists. Only four children were not provided with any form of mainstreaming.[1]

While all of the Head Start programs visited provided a mainstreaming experience of one type or another, this was not the case for the 46 non-Head Start programs visited. Seventeen of these programs offered a mainstream experience of one type or another, and of these, only 13 offered classroom mainstreaming.

Returning to the types of mainstreaming strategies adopted by Head Start programs, Table 3.2 presents the relationship between these strategies and the primary handicapping conditions of the 269 sample children. With few exceptions, these data indicate that the type of handicap affects the mode of mainstreaming very little. Because of the special problems presented by visually impaired and blind children, it is not surprising that these children were more frequently placed in mainstreaming situations that involved team teaching arrangements with special education professionals. It is not as clear as to why the learning disabled children in the sample were disproportionately involved in partially mainstreamed situations. These are the only two exceptions, though, to the relatively even distribution of handicapping conditions within mainstreaming mode.

In terms of mainstreaming mode and the severity of a child's handicap, Table 3.3 indicates only slight variations. Children with mild or moderate handicaps were more likely to be served in a total

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[1] These children were served in special facilities because of the extreme severity of their handicaps.

TABLE 3.1

Mainstreaming Modes Utilized by Head Start

Mainstreaming Mode[1]	Sample Children %
Complete, without supportive assistance	38.7 (N=104)
Complete, with supportive assistance	49.4 (N=133)
Complete, team taught by Special Education Teacher and Regular Teacher	4.4 (N=12)
Reverse Mainstreaming	1.5 (N=4)
Partial Mainstreaming	4.4 (N=12)
No Mainstreaming	1.5 (N=4)
Total	100.0 (N=269)

[1] Definitions of mainstreaming modes are discussed on page 3.2.

TABLE 3.2

Mode of Mainstreaming By Primary Handicap

Handicapping Condition	Types of Mainstreaming					
	Complete, Without Supportive Assistance % of Row	Complete, With Supportive Assistance % of Row	Complete, Team Taught by Special Education Teacher and Regular Teacher % of Row	Reverse Mainstreaming % of Row	Partial Mainstreaming % of Row	No Mainstreaming % of Row
Visually Impaired/Blind	28.6 (N=6)	42.9 (N=9)	23.8 (N=5)	*	*	4.7 (N=1)
Hearing Impaired/Deaf	52.2 (N=12)	47.8 (N=11)	*	*	*	*
Physically Handicapped	43.2 (N=16)	43.2 (N=16)	2.7 (N=1)	8.2 (N=3)	2.7 (N=1)	*
Speech Impaired	32.2 (N=19)	61.0 (N=36)	1.7 (N=1)	1.7 (N=1)	3.4 (N=2)	*
Health/Developmentally Impaired	53.3 (N=16)	40.0 (N=12)	3.3 (N=1)	*	3.3 (N=1)	*
Mentally Retarded	45.7 (N=16)	45.7 (N=16)	5.7 (N=2)	*	*	2.8 (N=1)
Learning Disabled	32.2 (N=10)	45.2 (N=14)	*	*	19.4 (N=6)	3.2 (N=1)
Seriously Emotionally Disturbed	27.4 (N=9)	57.6 (N=19)	6.0 (N=2)	*	6.0 (N=2)	3.0 (N=1

TABLE 3.3

Mode of Mainstreaming by Level of Handicap Severity

Severity Level	Types of Mainstreaming					
	Complete, Without Supportive Assistance % of Row	Complete, With Supportive Assistance % of Row	Complete, Team Taught by Special Education Teacher and Regular Teacher % of Row	Reserve Mainstreaming % of Row	Partial Mainstreaming % of Row	No Mainstreaming % of Row
Mild	45.9 (N=28)	47.5 (N=29)	3.3 (N=2)	*	3.3 (N=2)	*
Moderate	44.1 (N=49)	45.9 (N=51)	3.6 (N=4)	1.8 (N=2)	2.7 (N=3)	1.8 (N=2)
Severe/Profound	28.8 (N=23)	55.0 (N=44)	3.8 (N=3)	2.5 (N=2)	8.8 (N=7)	1.3 (N=1)
Other	23.5 (N=4)	52.9 (N=9)	17.6 (N=3)	*	*	5.9 (N=1)

mainstream context without supportive assistance than are more severely involved children. More severely involved children, on the other hand, are more often mainstreamed with supportive services or mainstreamed in situations that are more likely to involve reverse or partial mainstream strategies.

These data indicate that Head Start programs exhibit a degree of flexibility in the mainstreaming modes adopted depending on the level of handicap severity. *The more severe the disability the more likely the child was mainstreamed in a context other than simply in a classroom with non-handicapped peers and without supportive assistance.*

However, it should be noted that 104 (38.7%) children, including 23 classified as severely or profoundly handicapped, were mainstreamed without supportive assistance provided to the regular classroom teacher. Such an approach to mainstreaming may be appropriate for children with only mild impairments, but for the more severely involved children, mainstreaming without supportive classroom assistance either from other staff or outside professionals must be considered inappropriate. Although few non-Head Start programs included in this study provided mainstreaming experiences, it should be noted that of the 13 such programs offering classroom mainstreaming, none did so without providing supporting services to the teacher.

Time Spent in a Mainstreaming Context

Although a child may be considered completely mainstreamed by Head Start staff, there is a variety of interpretations as to what is meant by the word "complete." A question still remains as to the actual amount of time a child spends in a mainstreamed context. An investigation of this issue revealed that, overall, 83 percent of the sample children spent at least 90 percent of their time in a Head

Start center in a mainstreamed environment. Furthermore, fewer than 8 percent of the children spent less than 75 percent of their class time in a mainstreamed situation. These data varied insignificantly as a function of type of handicap. More severely involved children spent less time, on the average, in a mainstreamed situation than did the mild and moderately handicapped. However, differences as a function of handicap severity were minor and, in general, handicapped children in Head Start spent a substantial proportion of their class time in the company of their non-handicapped peers.[1]

Degree of Social Integration in the Classroom

Although Head Start children spend considerable time during a typical program day in a mainstreamed environment, it is also important to know whether the children were actually socially integrated into classroom activities. The benefits of a mainstreaming experience clearly demand more than the presence of a handicapped child in the same physical space with his/her non-handicapped peers. For mainstreaming to be effective, social exchange is necessary.

To investigate this issue, field staff conducted informal in-class observations of the 269 sample children. Observations were conducted over a 15 minute interval and as many as three observations were conducted for each child.[2] On the basis of these observations, field staff rated the degree to which children were socially integrated into ongoing classroom activities. Three levels of integration were considered:

- not socially integrated (child mostly isolated from group; few comments made to or by child);
- somewhat socially integrated (child in close proximity to others, but did not seem completely integrated);
- socially integrated (could not distinguish child from others on basis of social interaction).

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[1] Data pertaining to this issue can be found in Table A3.2 of Appendix A.

[2] All observations were conducted between 9:00 a.m. and 11:30 a.m. or during that period of a program day during which structured classroom activities were scheduled.

Table 3.4 presents the results of these observations. Of the children observed, more than 66 percent were judged to be fully integrated into Head Start classroom activities. Only 9.7 percent were judged to be social isolates.

The degree of social integration observed among the sample children did, however, vary by type of handicapping condition and degree of handicap severity. The relevant data are presented in Tables 3.5 and 3.6, respectively.

In terms of integration by type of handicap, those children whose handicap most likely affected social-emotional development were also those children least often judged to be socially integrated in their classes. Specifically, only 48.3 percent of children designated as mentally retarded and 52.2 percent of children designated as seriously emotionally disturbed were considered to be fully socially integrated.[1] Further, 20.7 percent of all mentally retarded children were judged to be socially isolated.

That these two groups of children exhibited a relative lack of social integration is not surprising. However, these data underline a challenge for Head Start to develop strategies to bring these children into the classroom mainstream despite the difficulties that their handicaps present.

Just as children with specific types of handicaps were less likely to be socially integrated in the classroom, Table 3.6 indicates that the more severe the handicap the less often full social integration was observed. More than 81 percent of the children with mild disabilities were judged to be fully socially integrated, whereas this

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[1] Learning disabled children also exhibited relatively low levels of social integration. This may be the result of the fact that several children so labeled were diagnosed as hyperactive. Hyperactivity would, of course, make it difficult for a child to achieve full social integration in the classroom according to criteria established.

TABLE 3.4

Degree of Social Integration of Handicapped Children in Head Start Programs	
Degree of Social Integration	% of Total
Not socially integrated (Child mostly isolated from group; few comments made to him or by him to others)	9.7 (N=23)
Somewhat socially integrated (Child in close proximity to others, but did not seem completely integrated)	23.9 (N=57)
Socially integrated (Could not distinguish this child from others on basis of social integration)	66.4 (N=158)
Total	100.0[1] (N=238)

[1] Observations were not conducted for 31 children.

TABLE 3.5

Degree of Social Integration by Primary Handicap

Social Integration	Visually Impaired/ Blind % of Column	Hearing Impaired/ Deaf % of Column	Physically Handicapped % of Column	Speech Impaired % of Column	Health/ Developmentally Impaired % of Column	Mentally Retarded % of Column	Learning Disabled % of Column	Seriously Emotionally Disturbed % of Column
Not Socially Integrated	5.3 (N=1)	13.0 (N=3)	12.5 (N=7)	5.7 (N=1)	3.6 (N=1)	20.7 (N=6)	10.7 (N=3)	8.6 (N=2)
Somewhat Socially Integrated	10.5 (N=2)	17.4 (N=4)	18.8 (N=6)	20.8 (N=11)	14.3 (N=4)	31.0 (N=9)	32.1 (N=9)	52.2 (N=12)
Socially Integrated	84.2 (N=16)	69.6 (N=16)	68.7 (N=22)	73.5 (N=39)	82.1 (N=23)	48.3 (N=14)	57.1 (N=16)	52.2 (N=12)
TOTAL	19	23	32	53	28	29	28	23

[1] Totals less than those indicated in Chapter 2 because observations could not be completed for 31 children.

TABLE 3.6

Degree of Social Integration by Handicap Severity

Degree of Social Integration	Mild % of Column	Moderate % of Column	Severe/Profound % of Column
Not socially integrated	3.7 (N=2)	8.2 (N=8)	14.0 (N=10)
Somewhat socially integrated	14.8 (N=8)	25.5 (N=25)	28.2 (N=20)
Socially Integrated	81.5 (N=44)	66.3 (N=65)	57.8 (N=41)
Total[1]	100.0 (N=54)	100.0 (N=98)	100.0 (N=71)

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[1] Totals less than those indicated in Chapter 2 because observations could not be completed for 31 children and an additional 15 did not have a level of handicap severity reported.

was so for only 57.8 percent of the children with severe/profound handicaps. Because Head Start's mandate is to emphasize services to severely disabled children, these data again underscore the need for further development of strategies to more fully mainstream children who, by reason of type of handicap or degree of disability, present particular problems for classroom integration. [*It should be noted, though, that despite the fact that severely involved children were less often fully integrated with their non-handicapped peers than children with milder handicaps, only 14 percent were judged to be social isolates.*]

Group Structure of the Mainstreaming Process

To further investigate the process of mainstreaming handicapped children in Project Head Start, field staff were also instructed to observe the group structure in which children were involved. Data pertaining to this issue are presented in Table 3.7. In keeping with data presented earlier concerning the degree of social integration observed among handicapped children, the most prevalent group structure observed was one in which the focus child was involved with a large group (5 or more children) of non-handicapped children. This situation was the most frequently observed across all observation periods and represented 52.2 percent of all observations recorded. The second most frequent group structure observed was one in which the focus child was involved with a small group (2-4 children) of non-handicapped children. In very few instances were handicapped children observed in "all handicapped" group situations (5.4% of all observations) and in only 11.1 percent of all observations were children observed in an isolated context.

In summary, the data presented in this and proceding sections indicate that in general Head Start has been successful in its effort to mainstream handicapped children into classroom activities. While this conclusion is based on informal observation and there are areas in which Head Start's mainstreaming strategies need continued development, it is clear that mainstreaming, in its broadest sense, is being

TABLE 3.7

Group Structures Observed in Head Start Classrooms

Group Structure	Observations 1st Observation % of Column	 2nd Observation % of Column	 3rd Observation % of Column	 Total Situations Observed % of Column
Individual	11.8 (N=36)	11.2 (N=18)	6.5 (N=3)	11.1 (N=57)
Individual with an Adult	12.5 (N=38)	10.6 (N=17)	8.7 (N=4)	11.5 (N=59)
Small group, All Handicapped	2.3 (N=7)	1.2 (N=2)	18.7 (N=4)	2.5 (N=13)
Small group with Normal Children	21.6 (N=66)	14.9 (N=24)	15.2 (N=7)	18.9 (N=97)
Large group, All Handicapped	3.3 (N=10)	2.4 (N=4)	2.2 (N=1)	2.9 (N=15)
Large group with Normal Children	48.5 (N=148)	60.2 (N=97)	58.7 (N=27)	52.9 (N=271)
Total	100.0 (N=305)	100.0 (N=161)	100.0 (N=46)	100.0 (N=512)

Note: Percentages were derived from number of different group situations observed. Some children were observed in two or more group settings per observation. Total children for each observation were: 1st observation, 249; 2nd observation, 145; 3rd observation, 44.

Note: A small group was defined as consisting of 2-4 children; a large group as 5 or more children.

accomplished. A more complete evaluation of Head Start mainstreaming, however, must await the results of data collected in the second phase of this study during which more systematic and comprehensive observational techniques will be utilized.

Program Facilities For Serving the Handicapped

While some Head Start programs served handicapped children long before the Congressional mandate required them to do so, many programs found it necessary to modify their program facilities and acquire special equipment and materials in order to effectively serve the handicapped in a mainstream setting. As part of the Phase I data collection activities, field staff conducted a walk-through in each classroom in which sample children were placed. The purpose of the walk-through was to note the presence or absence of facilities and materials that were considered important for adequately serving children with special needs in a classroom context. Walk-throughs were also conducted in the non-Head Start program sample. However, because no child-specific data were collected from these programs, the walk-through was conducted in a single classroom selected randomly.

The data from the walk-throughs are organized into four topic areas: 1) general structural facilities usually considered desirable for classrooms serving preschool handicapped children; 2) general instructional materials for development of gross motor, fine motor, self-help and visual/perceptual skills; 3) special materials and equipment specifically designed for handicapped children; and 4) the aesthetic quality of the classroom environment.

General Structural Facilities

Classroom walk-throughs revealed that Head Start and non-Head Start classrooms are generally similar in terms of structural facilities (Table 3.8). *The one major area in which non-Head Start classrooms show a decided advantage over Head Start*

TABLE 3.8

Structural Facilities in Program Classrooms

Facility	% of Classes with Facilities[1]	
	Head Start	Non-Head Start
Ramps	6.9 (N=10)	27.3 (N=12)
Doors to building can be pushed open by children	53.8 (N=78)	52.3 (N=23)
Doors to classroom can be pushed open by children	62.1 (N=90)	61.4 (N=27)
Doors to bathroom facilities can be pushed open by children	60.7 (N=88)	59.1 (N=26)
Wall-to-wall carpet in classroom	13.8 (N=20)	47.7 (N=21)
Large area rug in classroom	54.5 (N=79)	50.0 (N=22)
Mats or throw rugs for resting and nap time	65.5 (N=95)	59.1 (N=26)
Bathroom in an easily accessible location	71.0 (N=103)	86.4 (N=38)
Bathroom facilities are easily usable by handicapped and non-handicapped children	57.2 (N=83)	81.8 (N=36)
Sink is in an easily accessible location in the classroom	37.2 (N=54)	63.6 (N=28)
Sink is easily usable by handicapped and non-handicapped children	49.6 (N=72)	65.9 (N=29)
Play area inside	89.0 (N=129)	93.2 (N=41)
Play area outside	89.6 (N=130)	88.6 (N=39)
Child size furniture and equipment (tables, shelves, etc.)	99.3 (N=144)	97.7 (N=43)
Room dividers	61.4 (N=89)	63.6 (N=28)
Lockers or special area for hanging coats, hats, rubbers and putting extra change of clothes	79.3 (N=115)	79.5 (N=35)
Low open shelves for general storage and display of small toys and blocks	95.2 (N=138)	84.1 (N=37)
High shelves or closed cabinets for teachers use	79.3 (N=115)	90.9 (N=40)
Teacher's desk	53.1 (N=77)	68.2 (N=30)
First aid equipment	71.7 (N=104)	65.9 (N=29)
Open space for activities like block play, art and music	94.5 (N=137)	88.6 (N=39)
House play and dramatic play areas	86.2 (N=125)	68.2 (N=30)

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[1] Head Start percentages are based on a total of 145 classrooms in which the sample children were placed. This figure is smaller than the number of children (N=269) since, in most cases, the same classroom contained more than one sample child. Non-Head Start percentages are based on typical classrooms in 44 programs.

classrooms is in the area of bathroom and toilet facilities. Non-Head Start programs were more often equipped with facilities that were easily accessible and designed for use by handicapped children. This was not unexpected because in most instances classrooms in non-Head Start programs were constructed or modified specifically to meet the special needs of the handicapped. Head Start classrooms, for the most part, were not established specifically for providing services to the handicapped.

Head Start classrooms, on the other hand, were more often arranged to allow open space for house play and dramatic play activities.

General Classroom Equipment

In terms of general materials designed to develop gross and fine motor skills, self-help skills, and visual/perceptual skills, over 90 percent of all Head Start classrooms visited were well-equipped. This was also the case among the non-Head Start classrooms (Table 3.9).

Special Classroom Equipment

In addition to general classroom equipment, the particular needs and limitations of handicapped children often require the use of more specialized materials in order to conduct class activities. As Table 3.10 indicates, relatively few Head Start classrooms were equipped or had immediate access to these more specialized materials. This fact does not necessarily limit the ability of Head Start staff to provide appropriate instructional services to handicapped children because the kinds of materials which were considered are generally used in conjunction with the severely disabled. As indicated in Chapter 2, most of the handicapped children served in Head Start programs evidenced mild or moderate impairments. However, Head Start has been specifically charged to emphasize services to the more severely involved child.

TABLE 3.9

General Equipment in Program's Classrooms

Equipment	% of Total[1]	
	Head Start	Non-Head Start
Materials for gross motor development (balls, outdoor play equipment)	91.7 (N=133)	95.4 (N=42)
Materials for fine motor development (crayons, cars, blocks, modeling clay)	95.9 (N=139)	95.4 (N=42)
Self help materials (dolls, clothes, house play materials)	91.0 (N=132)	88.6 (N=39)
Visual materials (books, etc.)	97.2 (N=141)	93.2 (N=41)

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[1] Head Start percentages are based on a total of 145 classrooms in which the sample children were placed. This figure is smaller than the numer of children (N=269) since in most cases, the same classroom contained more than one sample child. Non-Head Start percentages arebased on typical classrooms in 44 programs.

TABLE 3.10

Availability of Special Equipment for Severely Handicapped Children in Program's Classrooms		
Equipment	% of Total[1]	
	Head Start	Non-Head Start
Special chairs, beds, wheelchairs, or other furniture	9.6 (N=14)	59.1 (N=26)
Special toys or equipment to develop fine or gross motor skills	24.1 (N=35)	56.8 (N=25)
Special audiovisual aids for the handicapped	14.5 (N=21)	68.2 (N=30)
Special books, charts, or other instructional materials	18.6 (N=27)	65.9 (N=29)
Special Instructional materials for parents of handicapped children	17.2 (N=25)	47.7 (N=21)
Other	6.9 (N=10)	20.4 (N=9)

[1] Head Start percentages are based on a total of 145 classrooms in which the sample children were placed. This figure is smaller than the number of children (N=269) since, in most cases, the same classroom contained more than one sample child. Non-Head Start percentages are based on typical classrooms in 44 programs.

The widespread lack of classroom materials generally considered necessary for imparting appropriate instructional/therapeutic services to the severely handicapped raises questions as to the capability of most Head Start programs to adequately serve severely and profoundly handicapped children.[1]

Non-Head Start programs, in comparison, were clearly better equipped with the kinds of special materials notably absent from Head Start classes (Table 3.10). Again, though, it must be recalled that the non-Head Start programs were for the most part designed to specifically serve handicapped children and it was not unexpected that their classes should be better supplied with specialized equipment.

Aesthetic Quality of Classrooms

The availability of equipment and materials describes only one aspect of the context in which Head Start mainstreams handicapped children. Another consideration is the aesthetic nature of the classroom environment. Clearly, a bright and attractive classroom interior contributes to a positive learning situation, whereas a dark room and drab interior establishes barriers to productive and enjoyable classroom activities.

Using a ranking system modified from nursing home and day care evaluations, field staff judged the aesthetic qualities of the classrooms visited. A classroom was placed into one of four categories according to three basic criteria:

- quality of displays, bulletin boards, and color schemes

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[1] It may be argued that the lack of specialized materials simply reflects the fact that most Head Start programs do not serve severely handicapped children and, therefore, have no need to invest in such materials. However, the absence of these materials also hinders effective outreach efforts designed to bring more severely impaired children into Head Start programs.

- adequacy of lighting taking into account artificial as well as natural lighting sources
- degree of cleanliness based on presence/absence of visible filth and observable odors.

Classrooms were ranked "excellent," "good," "fair," or "poor" according to these criteria.

As can be seen in Table 3.11, more than 60 percent of all Head Start classrooms were considered to have excellent aesthetic qualities. Another 30 percent were judged to be good and 5.5 percent were considered only fair. In no instances did project staff encounter Head Start classrooms that were in poor condition.

In comparison, more than 70 percent of the non-Head Start classrooms were considered to possess excellent aesthetic qualities and the balance (27.3%) were judged to be good. No classrooms were perceived to be only fair or poor.

The preceding data have indicated that Head Start programs have few areas in which their facilities and materials are inadequate to meet the special needs of handicapped children in a mainstreamed setting. In several instances field staff visited Head Start programs that had access to truly outstanding facilities.

In comparison, though, non-Head Start programs serving the preschool handicapped had facilities and materials that were generally superior to those available to Head Start programs. Superior facilities and materials do not necessarily indicate higher quality services. However, this does indicate that non-Head Start programs are generally in a better position to meet the special needs of handicapped children, particularly those that are severely disabled.

The difference in facilities and materials between Head Start and non-Head Start is no doubt a function of many factors, not the least of which is the basic difference in purposes for which Head Start and non-Head Start programs were established.

TABLE 3.11

Ratings of Condition of Environment in Program's Classrooms

Ratings	% of Total Head Start	 Non-Head Start
Excellent (clean; no odors; attractive displays; well lighted; etc.).	62.8 (N=91)	72.7 (N=32)
Good (no odors or visible filth, but lacks attractive interior; adequately lighted).	30.3 (N=44)	27.3 (N=12)
Fair (no or poorly developed displays; odors, but no visible filth; poorly to fairly lighted).	5.5 (N=8)	*
Poor (visible filth; dark)	*	*
Total[1]	100.0 (N=143)	100.0 (N=44)

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[1] Sample Head Start children (N=269) were placed in a total of 145 classrooms. Data were unavailable for two classrooms. Head Start percentages are, therefore, based on 143 classrooms. Non-Head Start percentages are based on typical classrooms in 44 programs.

Certainly it should be expected that a program with a primary mission to serve handicapped children would be better equipped for this purpose than programs whose primary mission is to mitigate the debilitating effects of economic disadvantage upon a child's ability to successfully adapt in a public school context. Nevertheless, if Head Start is to continue to recruit and enroll handicapped children, stronger efforts will have to be made to ensure that such children have available the necessary materials and equipment to support their mainstreaming experiences.

Although recommendations as to how the Administration for Children, Youth and Families might proceed to ensure the availability of these supportive resources are presented in a later chapter, it is interesting to review patterns of pupil expenditures between Head Start and non-Head Start programs. The relevant data are presented in Table 3.12 and 3.13. Table 3.12 examines handicapped pupil expenditure ratios in terms of funds and the estimated value of in-kind services specifically earmarked for handicapped services for Head Start and non-Head Start programs, respectively. Table 3.13 examines pupil expenditure ratios for total enrollments by total program funding for Head Start and non-Head Start programs, respectively.

In terms of funds and services specifically earmarked for the handicapped, 50 percent of the Head Start programs visited reported expenditures of more than $1,500 per handicapped child over the course of the program year. Of the non-Head Start programs providing information relevant to this issue (40 of 46 programs), 70 percent reported expenditures in excess of $1,500 per child.

The difference in pupil expenditure ratios between Head Start and non-Head Start programs is even more dramatic when all funding sources are considered. Fifty percent of the non-Head Start programs visited reported total pupil expenditures of over $5,000 per child

TABLE 3.12

Program Handicapped Pupil Expenditure Ratio[1]

Per Handicapped Pupil Expenditure	Head Start % of Total	Non-Head Start % of Total
$ 1 - $ 500	10.2 (N=6)	15.0 (N=6)
$ 501 - $1000	18.6 (N=11)	7.5 (N=3)
$1001 - $1500	20.4 (N=12)	7.5 (N=3)
$1501 - $2500	15.2 (N=9)	12.5 (N=5)
$2501 - $5000	15.2 (N=9)	20.0 (N=8)
Over $5000	20.4 (N=12)	37.5 (N=15)
Total	100.0 (N=59)	100.0 (N=40)[2]

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[1] Defined as funds earmarked for the handicapped + estimated value of inkind services to handicapped children ÷ the number of handicapped children served.

[2] Six non-Head Start programs did not provide information relevant to this issue.

TABLE 3.13

Total Pupil Expenditure Ratio[1]		
Per Pupil Expenditure	Head Start % of Total	Non-Head Start % of Total
$ 1 - $ 500	1.7 (N=1)	5.0 (N=2)
$ 501 - $1000	12.3 (N=7)	2.5 (N=1)
$1001 - $1500	42.1 (N=24)	5.0 (N=2)
$1501 - $2500	31.6 (N=18)	22.5 (N=9)
$2501 - $5000	7.0 (N=4)	15.0 (N=6)
Over $5000	5.3 (N=3)	50.0 (N=20)
Total	100.0 (N=57)[2]	100.0 (N=40)[3]

[1] Defined as total funding ÷ total children enrolled in a program.

[2] Two Head Start programs did not provide relevant information.

[3] Six non-Head Start programs did not provide relevant information.

over the course of the program year. Only 5 percent of the Head Start programs reported similar expenditure ratios. In all, over 87 percent of the non-Head Start programs spent more than $1,500 a year per child while this is true for only 42 percent of the Head Start programs. Clearly, one of the key reasons why non-Head Start programs evidence superior facilities and materials was a function of a significant funding advantage vis-a-vis their Head Start counterparts.

Whether this superiority in funding is related to the quality of services provided to handicapped children remains open to question.

Summary of Findings

- More than 90 percent of the Head Start children included in this study were completely mainstreamed in the sense that they spent nearly all their program time in the company of non-handicapped peers. Fifty-four percent were in mainstreaming situations in which services were provided by professional specialists to augment core Head Start staff capabilities.
- Only 13 of the 46 non-Head Start programs visited provided a classroom mainstreaming experience. However, in each of these 13 programs, the regular classroom teacher was provided supportive services by professionals and specialists.
- The nature of a child's handicap and the severity of the handicap affects the mode of mainstreaming only slightly. Severely disabled children were more likely to be in mainstreaming settings in which the Head Start classroom teacher received supportive services.
- Most children who were considered to be "completely" mainstreamed spent over 90 percent of their time in a typical day in the company of non-handicapped peers.
- More than 66 percent of the 269 children observed were judged to be fully integrated into classroom activities. Children diagnosed as mentally retarded or emotionally disturbed were less likely to be fully socially integrated than children with other handicaps. Fifty-seven percent of those children with severe or profound disabilities were judged to be socially integrated whereas this was so for 81 percent of those children with mild impairments.

- In nearly 85 percent of all informal in-class observations conducted by field staff, the focus child was observed in a group structure that included non-handicapped peers. In only 5 percent of these observations was the focus child involved in social situations that included only handicapped children.
- Facilities and materials available to Head Start programs to support the mainstreaming handicapped children are generally adequate for children with mild or moderate impairments. Head Start programs, though, often do not have the special equipment or materials that would facilitate the delivery of services to severely handicapped children.
- Pupil expenditure ratios, both in terms of total funding available and funding earmarked specifically for the handicapped (including in-kind services), are substantially higher in non-Head Start programs. However, it is not clear whether this funding advantage is related to the quality of services received by handicapped children.

4

STAFF CHARACTERISTICS

The characteristics of classroom staff are, perhaps, one of the most important aspects of preschool programs because the staff determines to a significant degree the quality of program experiences in which the children spend most of their time. Consequently, the pre-service preparation and in-service training of staff serving handicapped children are of interest as one set of indicators of the nature of the services provided to children. Specifically, the following staff-related issues were addressed in the Phase I study:

- What is the educational background of the staff of the sample children, including degree obtained, areas of emphasis, and certification? Are the staff trained in areas that equip them to serve handicapped children?
- What types of training were offered to staff serving the sample children? How frequently? Who provided the training?
- What types of training did the Head Start programs offer to their staff in general?
- In what areas did staff of the sample children request additional training?
- What is the educational background of staff who worked with handicapped children in non-Head Start programs? Were they certified? In what areas?
- In what areas did non-Head Start programs typically provide training to staff of handicapped children? Who provided the training?
- How do the general patterns of staffing and training compare between Head Start and non-Head Start programs?

Descriptive information was collected on all Head Start staff who served one or more of the sample 269 handicapped children. Data on Head Start staff characteristics are specific to the type of staff under consideration (e.g., teachers, aides, and educational/handicap coordinators) and are child-specific. Data on staffing patterns of non-Head Start programs are program-specific.

Class Staffing Patterns

Most of the 269 Head Start children were served in classrooms in which the ratio of students to teachers was 1 to 10 or less (179, or 61%). On the other hand, 16.7 percent of the sample children (45) were served in classrooms in which the pupil/teacher ratio was greater than 1 to 15. For seven children, the teacher/pupil ratio exceeded 1 to 30.[1]

"Teaming" was not a widely practiced instructional strategy for handicapped children in Head Start. Forty-five percent (122) of the children were served by a single teacher (plus aide) and another 38.2 percent were served by two teachers.

Educational Background of Staff

The educational level of three Head Start staff positions - educational/handicap coordinators, teachers, and aides - is shown in Table 4.1. Degree area of the staff with college degrees is shown in Table 4.2. Of the 140 coordinators who were employed by the Head Start programs visited, 121 were college graduates (84 of whom also had postgraduate training). No educational

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[1] The presence of paid aides and volunteers in classrooms results in a much lower pupil/adult ratio. However, data pertaining to this issue are unreliable due to the fluctuating numbers of paraprofessionals and volunteer adults in Head Start classes. More complete data pertaining to this issue will be examined in Phase II.

TABLE 4.1

Educational Levels of Head Start Staff[1]						
Staff Position	Total % of Row	Less than high school % of Row	High school graduate % of Row	Associate degree/ some college % of Row	College graduate % of Row	Postgraduate education % of Row
Educational Coordinator	100.0 (N=140)	*	*	13.6 (N=19)	26.4 (N=37)	60.0 (N=84)
Teacher	100.0 (N=356)	2.8 (N=10)	14.3 (N=51)	40.4 (N=144)	23.9 (N=85)	18.6 (N=66)
Aide	100.0 (N=324)	17.6 (N=57)	44.7 (N=145)	35.2 (N=114)	2.5 (N=8)	*

[1] Data are staff-specific

TABLE 4.2

Degree Areas of Head Start Staff by Staff Level[1]					
Staff Position	Total[2] % of Row	Special Education % of Row	Early Childhood Development % of Row	Other % of Row	No Response % of Row
Classroom Teacher	100.0 (N=151)	9.9 (N=15)	29.8 (N=45)	51.6 (N=78)	8.6 (N=13)
Aide	100.0 (N=8)	12.5 (N=1)	25.0 (N=2)	62.5 (N=5)	*
Educational Coordinator	100.0 (N=121)	14.0 (N=17)	39.7 (N=48)	37.2 (N=45)	9.1 (N=11)

[1] Data are staff-specific

[2] Includes only those staff who hold at least a college degree.

coordinator had less than a high school education. One hundred forty-four teachers had an associate degree or some college (40.0%), and 151 had at least an undergraduate degree (42.5%). Aides were predominantly high school graduates (44.7%) or had an associate degree or some college (35.2%). A sizable proportion of this group, though, had less than a high school education (17.6%).

Of those staff who had at least a college degree, very few had degrees in special education and about 30 percent had degrees in early childhood development. This pattern is the same for all staffing positions. *The relative predominance of backgrounds in early childhood education is very appropriate considering the primary service population of Head Start, but these data also indicate that only 10 percent of all staff who directly interacted with the sample children had primary training in special education. This fact does not vary as a function of the type or severity of handicaps served. Classrooms of most sample children, then, were staffed by personnel without backgrounds related to special education.*

Although only 20 of the sample children were in programs that required staff to meet State special education certification requirements it is important to point out that only 24 of the 140 educational coordinators (17.1%) and 28 of the 356 teachers (7.9%) involved with the sample children were certified by their respective State Education Agencies to work with exceptional children.

Training Provided to Head Start Staff

The Administration for Children, Youth and Families has expended a considerable amount of money to provide Head Start with training and instruction that would in part permit teachers to work effectively with handicapped children. Several previous reports prepared for ACYF have outlined in detail the various components of this training effort.

As part of the Phase I Study, Head Start training activities were again investigated. However, rather than looking at training activities from a program perspective, the Phase I Study focused on the training received by staff responsible for each of the 269 sample children. Moreover, particular attention was given to training specifically designed to prepare staff to work with handicapped children.

Table 4.3 presents these data in terms of the type of training received by Head Start staff. One of the more interesting facts indicated by Table 4.3 is that with a few minor exceptions no more than half of the sample children were served by staff (educational/handicap coordinators, teachers, aides) who had received training in any one of the areas outlined. *Less than half of the children were served by staff who had received training in the development of individual learning objectives. More importantly, only 31 percent were served by staff who had received training specific to the nature of their disability. Finally, only 14 percent were served by staff who had received inservice instruction concerning the theory and practice of mainstreaming.*

In terms of the amount of training Head Start staff received relative to handicapped children, Table 4.3 indicates that no more than 22 percent of the sample children were served by staff who had received in excess of 15 hours' instruction in any one training area.[1/]

This relative lack of inservice training is also not compensated for by staff participation in Child Development Associate (CDA) programs. Of the 344 educational/handicap coordinators, teachers, and aides serving the sample children, only 7 percent (9 educational/handicap coordinators, 13 teachers, and 2 aides) were credentialed CDAs. Another 20 percent were participating in CDA programs but had not yet completed training.

In terms of the professionals providing inservice training, Table 4.4 indicates that most training was provided by Head

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[1/] The number of hours spent in inservice training was reported only for the 1977 program year. Staff continuity over several years would, of course, result in staff with more extensive training.

TABLE 4.3

Head Start Staff Inservice Training Time by Training Type[1]							
Training Type	Total % of Row	No Specific Training % of Row	Time Not Specified % of Row	Hours of Inservice Training 1-5 Hours % of Row	6-10 Hours % of Row	11-15 Hours % of Row	Over 15 Hours % of Row
Knowledge of Head Start Standards	100.0 (N=269)	49.1 (N=132)	.4 (N=1)	13.8 (N=37)	19.7 (N=53)	.8 (N=2)	13.0 (N=35)
Behavior Management	100.0 (N=269)	45.0 (N=121)	.4 (N=1)	16.4 (N=44)	14.5 (N=39)	1.5 (N=4)	22.3 (N=60)
Individualized Instruction	100.0 (N=269)	49.1 (N=132)	*	14.1 (N=38)	13.8 (N=37)	4.8 (N=13)	14.9 (N=40)
Individual Learning Objectives	100.0 (N=269)	51.3 (N=138)	*	14.9 (N=40)	15.2 (N=41)	3.7 (N=10)	14.9 (N=40)
Working With Parents	100.0 (N=269)	55.4 (N=149)	.4 (N=1)	14.1 (N=38)	13.8 (N=37)	*	16.4 (N=44)
Strategies to Recruit Handicapped Students	100.0 (N=269)	88.8 (N=239)	.4 (N=1)	2.6 (N=7)	3.0 (N=8)	*	5.2 (N=14)
Screening and Assessment	100.0 (N=269)	61.7 (N=166)	*	16.4 (N=44)	8.2 (N=22)	1.5 (N=4)	12.3 (N=33)
Theory and Practice of Mainstreaming	100.0 (N=269)	86.2 (N=232)	*	1.9 (N=5)	1.5 (N=4)	3.3 (N=9)	7.1 (N=19)
Specific Training for One Child's Handicap	100.0 (N=269)	69.5 (N=187)	*	8.9 (N=24)	7.4 (N=20)	3.7 (N=10)	10.4 (N=28)
Understanding Handicapping Conditions	100.0 (N=269)	41.2 (N=111)	.4 (N=1)	17.5 (N=47)	18.6 (N=50)	2.6 (N=7)	19.7 (N=53)
Other	100.0 (N=269)	79.9 (N=215)	*	6.3 (N=17)	7.1 (N=19)	*	7.8 (N=21)

[1] This table only includes training each child's staff received related to handicapped children. Date are child-specific.

TABLE 4.4

Head Start Staff Inservice Training Type by Provider[1]

Training Type		Type of Provider							
	Total[2] % of Row	Resource Acess Program % of Row	Head Start Personnel % of Row	Public School Personnel % of Row	University/ College % of Row	Private Consultant % of Row	Public Health Dept. % of Row	Private Organization % of Row	Other[3] % of Row
Knowledge of Head Start Standards	100.0 (N=137)	1.4 (N=2)	84.7 (N=116)	5.1 (N=7)	6.6 (N=9)	*	*	*	2.2 (N=3)
Behavior Management	100.0 (N=140)	*	15.7 (N=22)	2.2 (N=3)	21.4 (N=30)	30.7 (N=43)	9.3 (N=13)	1.4 (N=2)	19.3 (N=27)
Individualized Instruction	100.0 (N=124)	16.9 (N=21)	34.7 (N=43)	13.8 (N=17)	16.9 (N=21)	2.4 (N=3)	*	4.0 (N=5)	11.3 (N=14)
Individual Learning Objectives	100.0 (N=129)	*	49.6 (N=64)	5.5 (N=7)	15.5 (N=20)	15.5 (N=20)	*	2.3 (N=3)	11.6 (N=15)
Working With Parents	100.0 (N=120)	0.8 (N=1)	55.8 (N=67)	5.0 (N=6)	7.5 (N=9)	12.5 (N=15)	2.6 (N=3)	*	15.8 (N=19)
Strategies to Recruit Handicapped Students	100.0 (N=30)	36.7 (N=11)	30.0 (N=9)	*	10.0 (N=3)	20.0 (N=6)		3.3 (N=1)	*
Screening and Assessment	100.0 (N=101)	*	56.5 (N=57)	4.0 (N=4)	15.8 (N=16)	5.9 (N=6)	1.0 (N=1)	5.9 (N=6)	10.9 (N=11)
Theory and Practice of Mainstreaming	100.0 (N=30)	*	16.7 (N=5)	16.7 (N=5)	10.0 (N=3)	16.7 (N=5)	*	13.3 (N=4)	26.6 (N=8)
Specific Training for One Child's Handicap	100.0 (N=80)	12.6 (N=10)	20.0 (N=16)	16.2 (N=13)	11.2 (N=9)	10.0 (N=8)	*	18.8 (N=15)	11.2 (N=9)
Understanding Handicapping Conditions	100.0 (N=146)	*	30.1 (N=44)	6.2 (N=9)	14.4 (N=21)	23.3 (N=34)	1.4 (N=2)	6.8 (N=10)	17.8 (N=26)
Other	100.0 (N=54)	*	16.8 (N=9)	1.8 (N=1)	11.1 (N=6)	7.4 (N=4)	11.1 (N=6)	11.1 (N=6)	40.7 (N=22)

[1] This Table only includes training each child's staff received related to handicapped children. Data are child-specific.

[2] Each row total represents the number of children whose staff received the corresponding type of training. Totals are based on providers indicated.

[3] Includes BEH and University Affiliated Facilities.

start personnel. In specific areas such as behavior management and the theory and practice of mainstreaming, training was more often provided by professionals outside of Head Start (generally private consultants). *However, training was infrequently provided through Resource Access Programs, public health departments, or public schools.*

Perceived Training Needs

Respondents were asked to indicate the areas in which staff serving each of the sample children required additional training and instruction. Referring to the same training areas outlined in Tables 4.3 and 4.4, respondents were asked to indicate, for each child, which training area would have the highest priority, second highest priority, etc. The results of this investigation are presented in Table 4.5.

Training specific to children's particular handicaps was most often cited as the highest training priority. Assistance in developing individualized learning objectives and instruction in understanding handicapping conditions were also often cited as training priorities. Training in the theory and practice of mainstreaming was not often considered a training priority. Neither was instruction regarding Head Start performance standards. Based on the findings of later chapters this last point is a cause for concern. While familiarity with performance standards may not be important in the delivery of services to an individual child, many of the shortcomings observed relative to the Head Start handicapped effort would be nonexistent if current regulations were more fully understood.

Characteristics of Non-Head Start Program Staff

Most of the non-Head Start programs (35, or 76%) staffed classrooms containing at least one handicapped child with 1 to 2 teachers. These teachers had instructional responsibility in the classroom - not just child supervision or assistance. An additional 15 percent

TABLE 4.5

Additional Training Requested for Head Start Staff by Priority Ranking[1]											
Priority	Training Types										
	Knowledge of Head Start Performance Standards % of Column	Behavior Modification/ Classroom Management % of Column	Individualized Instructional Techniques % of Column	Preparation of Individual Learning Objectives % of Column	Working With Parents % of Column	Strategies for Recruitment of Handicapped Children % of Column	Screening and Assessment % of Column	Theory and Practice of Mainstreaming % of Column	Working With This Child's Handicap % of Column	Understanding Handicapping Conditions % of Column	Other % of Column
Total	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)	100.0 (N=269)
Highest Priority	1.1 (N=3)	5.9 (N=16)	12.6 (N=34)	7.4 (N=20)	8.2 (N=22)	1.9 (N=5)	3.7 (N=10)	1.9 (n=5)	29.7 (N=80)	11.9 (N=32)	4.8 (N=13)
Next Highest Priority	*	7.1 (N=19)	14.1 (N=38)	11.9 (N=32)	6.7 (N=18)	1.1 (N=3)	6.3 (N=17)	3.3 (N=9)	17.8 (N=48)	16.7 (N=45)	0.7 (N=2)
Other Priorities	7.8 (N=21)	17.9 (N=48)	31.3 (N=48)	26.4 (N=71)	35.7 (N=96)	13.0 (N=35)	16.4 (N=44)	17.5 (N=47)	19.4 (N=52)	24.6 (N=66)	4.5 (N=12)
Not a Priority	91.1 (N=245)	69.1 (N-186)	42.0 (N=113)	54.3 (N=146)	49.4 (N=133)	84.0 (N=226)	73.6 (N=198)	77.3 (N=208)	33.1 (N=89)	46.8 (N=126)	90.0 (N=242)

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[1] Data are child-specific

used from 3 to 7 instructional personnel. Only 6 percent used none; these programs provided only custodial or recreational services to the children they served. Non-Head Start programs tended to have two or more teachers (65%) who had instructional contact with the same handicapped child.

Educational Background of Staff

Table 4.6 shows the overall education level for classroom staff in non-Head Start programs. The majority were college graduates (84.3%) with 25.1 percent having some post graduate education. Only 7.3 percent had a high school degree or less. *These data reveal that non-Head Start staff had considerably higher levels of academic training than their Head Start counterparts. Non-Head Start staff had twice the proportion of college graduates and four times the proportion of teachers with at least some college credits.*

Table 4.6 shows the same information for aides in non-Head Start programs. Fifty-three percent were high school graduates and 37 percent had at least some college or a college degree. This is comparable to the educational backgrounds of Head Start aides (see Table 4.1).

Table 4.7 presents information on degree areas for non-Head Start staff by staff positions. *Notable is the heavy emphasis in special education (44%) for classroom teachers and the almost exclusive employment of staff degreed in "other" areas for all other staff positions.*[1] Unlike Head Start staff, there were relatively few non-Head Start staff with a degree in early childhood development.

Thirty-eight percent of all teachers in non-Head Start programs were certified by State Education Agencies in the area of special education compared to only eight percent of the teachers in Head Start.

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[1] This emphasis no doubt reflects State certification requirements imposed upon many non-Head Start programs.

TABLE 4.6

Educational Level of Non-Head Start Staff by Staff Position

Staff Position		Highest Educational Level Obtained				
	Total[1] % of Row	Less than High School % of Row	High School Graduates % of Row	Associate degree/ some college % of Row	College Graduate % of Row	Postgraduate Education % of Row
Teachers	100.0 (N=191)	2.1 (N=4)	5.2 (N=10)	8.4 (N=16)	59.2 (N=113)	25.1 (N=48)
Aides	100.0 (N=170)	7.0 (N=12)	53.5 (N=91)	24.7 (N=42)	12.4 (N=21)	2.4 (N=4)

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[1] Row totals represent the total number of staff of that position within the program who provided services to one or more handicapped children. Data are staff-specific.

TABLE 4. 7

Non-Head Start Program Staff Levels by Degree Area[1]

Degree Area Number of Staff for a Typical Classroom	Staff Level Classroom Teacher % of Column	Aide % of Column	Other % of Column
Total	100.0 (N=56)	100.0 (N=9)	100.0 (N=7)
Special Education			
1 Staff	17.9 (N=10)	11.1 (N=1)	14.3 (N=1)
2 or More Staff	26.8 (N=15)	*	*
Early Childhood Development			
1 Staff	12.5 (N=7)	11.1 (N=1)	14.3 (N=1)
2 or More Staff	8.9 (N=5)	*	*
Other			
1 Staff	12.5 (N=7)	22.2 (N=2)	57.1 (N=4)
2 or More Staff	21.4 (N=12)	55.6 (N=5)	14.3 (N=1)

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[1] Data are staff-specific

Overall, the staff in non-Head Start programs had higher proportional representation in special education, more advanced training and more often taught in team situations than staff in Head Start programs.

Training Provided to Non-Head Start Program Staff

The data presented on training offered in this section are program-specific, whereas the Head Start training data were child-specific. Nevertheless, limited comparisons about in-service training can be made between the two types of programs.

Non-Head Start programs most frequently offered training in the areas of behavior management (80.4% of the programs), individualized instruction (78.3%), and preparation of learning objectives (70.0%) (see Table 4.8). These are all areas that were only moderately emphasized among Head Start staff.

Non-Head Start programs infrequently offered training in areas related specifically to handicapped children. Training in understanding handicapping conditions and recruitment of handicapped children was offered in 32.6 percent and 8.7 percent of the programs, respectively. Training in understanding handicapping conditions was most often provided to the staff of the sample Head Start children. *Thus, it seems that training specific to handicapped children was more frequently offered to Head Start than non-Head Start program staff.* This is consistent with the fact that a larger proportion of non-Head Start staff already were trained in special education and/or were employed by categorical programs. Consequently, supplemental training in understanding handicapping conditions would not be as critical.

Just as Head Start staff were the predominant providers of training in Head Start programs, staff from the non-Head Start programs, most frequently offered the training in their respective programs. However, the non-Head Start programs relied more often upon public school personnel for training than did Head Start programs.

TABLE 4.8

Provider Type by Inservice Training Type for Non-Head Start Program Training[1/]

Type of Provider	Type of Inservice Training							
	Behavior Management % of Column	Individualized Instruction % of Column	Preparation of Learning Objectives % of Column	Working With Parents % of Column	Recruitment of Handicapped Children % of Column	Screening and Assessment % of Column	Understanding Handicapping Conditions % of Column	Other % of Column
Total	100.0 (N=37)	100.0 (N=36)	100.0 (N=32)	100.0 (N=23)	100.0 (N=4)	100.0 (N=20)	100.0 (N=15)	100.0 (N=11)
Public School	21.6 (N=8)	19.4 (N=7)	21.9 (N=7)	30.4 (N=7)	25.0 (N=1)	35.0 (N=7)	20.0 (N=3)	*
University/College	24.3 (N=9)	22.2 (N=8)	12.5 (N=4)	8.7 (N=2)	*	15.0 (N=3)	26.7 (N=4)	18.1 (N=2)
Public Health Department	*	*	*	*	*	*	*	9.1 (N=1)
Private Clinician	10.8 (N=4)	11.1 (N=4)	3.1 (N=1)	21.7 (N=5)	*	5.0 (N=1)	6.6 (N=1)	36.4 (N=4)
State Education Agency	5.5 (N=2)	5.6 (N=2)	6.2 (N=2)	4.4 (N=1)	25.0 (N=1)	*	*	*
Other	37.8 (N=14)	41.7 (N=15)	56.3 (N=18)	34.8 (N=8)	50.0 (N=2)	45.0 (N=9)	46.7 (N=7)	36.4 (N=4)

[1/] Data are program-specific. Each program may have offered more than one type of training and may, thus, be represented in more than one column.

This is not surprising considering the public school affiliation of some of the non-Head Start programs.

Summary of Findings

- Few of the Head Start staff who interacted with the sample children were trained in special education. Head Start staff did not often have formal educational backgrounds in areas that would have prepared them to serve handicapped children. Moreover, staff of many of the sample children received only limited inservice training in areas related to service delivery to handicapped children. Few children were served by teachers who had specific training in the theory and practice of mainstreaming. An indication that more training is needed is that staff of the sample children most frequently requested additional training in handicap-related areas.
- Inservice Head Start staff training was primarily offered in areas related to handicaps and handicapped children and second most frequently in areas related to individualized instruction and learning. Across training areas, Head Start personnel primarily offered the training.
- The majority of the educational coordinators who worked with the sample children had some post-graduate training; most of the children's teachers were college graduates (43%) or had at least some college education (40%). Children's aides primarily were high school graduates (45%) or had at least some college (35%).
- Very few of the Head Start staff were credentialed Child Development Associates, although approximately 20 percent of all staff were participating in CDA programs.
- Most of the non-Head Start programs staffed classrooms which contained handicapped children with 1 or 2 teachers. While the teachers who had contact with handicapped children in the non-Head Start programs had a higher overall education level than the teachers of the sample head Start programs, the educational levels of the classroom aides is similar between program types. Far more non-Head Start staff were trained in special education than Head Start staff which is, in part, a reflection of State certification requirements which more often pertain to non-Head Start programs.

5

PROGRAM ENTRY AND TERMINATION

Unless impairments are obvious or parents are knowledgeable about normal childhood development, handicaps among preschool children are often overlooked or ignored until entry into the public school system. Furthermore, even in the case of obvious impairment, many parents are either too ashamed to seek help or are unaware that help is available for their child.

Therefore, a primary component of the Head Start effort to serve the handicapped is the development of effective outreach and recruitment procedures to ensure that all children who might benefit from and are eligible for Head Start services are provided the opportunity to enroll. The more exhaustive these outreach and recruitment procedures are, the more effectively Head Start programs can meet their philosophical and legal commitment to serve the handicapped.

This chapter examines the recruitment and enrollment practices of the Head Start and non-Head Start programs visited. It also examines the specific ways in which the sample of Head Start children actually came to be enrolled in their respective programs. Data from these investigations address the following issues:

- How did the sample handicapped children come to the attention of the Head Start programs?
- What types of outreach/recruitment procedures did the Head Start programs typically use for purposes of enrolling handicapped children? Are outreach activities targeted at handicapped children?

- Did the Head Start programs compete with other agencies to enroll handicapped children?
- Did the Head Start programs identify handicapped children whom they could not/did not enroll? If so, why? What referral services did Head Start provide to these children?
- What types of outreach/recruitment procedures, if any, did the non-Head Start programs typically use for purposes of enrolling handicapped children?
- How do the program entry procedures of Head Start programs compare to those of non-Head Start programs?

Also examined are the conditions surrounding termination of children from the Head Start programs. The reasons for termination are important because they potentially indicate areas in which Head Start programs were unable to provide appropriate or adequate services to handicapped children. Data presented concerning Head Start termination practices address the following issues:

- How many programs terminated handicapped children from the programs? In how many programs did handicapped children voluntarily withdraw from the program? What were the reasons for termination?
- What follow-up services did Head Start provide to terminated children?

This chapter is divided into four sections: Head Start Enrollment Practices, Non-Head Start Enrollment Practices, Incidence of Non-Enrollment in Head Start Programs, and Incidence of Discontinuation in Head Start Programs. Data in the first section are child- and program-specific; data in the latter three sections are program-specific.

Head Start Enrollment

This section considers the manner in which the sample children came to the attention of their Head Start programs; competition that the programs have experienced with other agencies over enrollment of handicapped children; entrance requirements established by the Head Start programs; and program options that were available to the sample children upon enrollment.

Ways Children Come to Attention of Head Start

In general, almost all of the Head Start programs in the sample indicated that they used specific procedures (i.e., some type of outreach/recruitment/child find activity) for identifying preschool handicapped children, as opposed to only enrolling handicapped children who seek admission to the program. Extensive use is made of broadcast and printed media in this regard. Only 3 (5.6%) of the 54 Head Start programs who responded to this question did not engage in some special activity to recruit handicapped preschoolers.

However, as Table 5.1 indicates, most of the sample handicapped children were enrolled through the same procedures used to enroll non-handicapped preschoolers. With the exception of the children referred from other agencies, very few of the children were identified as a result of outreach activities specifically designed to locate handicapped children.[1/] That is, over half (53.5%) of the children were enrolled in their programs as a result of recruitment/child find activities that were a part of the program's normal recruitment procedures.[2/]

On the other hand 70 children (26%) were referred to Head Start by another agency specifically because the children in question were handicapped. Therefore, while few handicapped children were identified through special outreach efforts, Head Start programs have, to a degree, established linkages with other local agencies to identify potential handicapped enrollees.

Of the 76[3/] children who were referred to Head Start by outside agencies, no one agency made referrals involving a large proportion of the children (see Table 5.2). The public schools were involved in 14

[1/] Referrals from other agencies were considered evidence of outreach activities since some programs were a part of referral networks and informed other agencies of their services to handicapped children.

[2/] This point is reinforced in Chapter 7. Only 90 children came to Head Start with previously diagnosed handicaps, and most of these children were those referred to Head Start by other agencies/parents.

[3/] The total of 76 includes six children referred by outside agencies but not because of suspected handicaps.

TABLE 5.1

How Handicapped Children Came to the Attention of Head Start Programs	
Manner of Recruitment	% of Total
Referred by outside agency, not because of handicap	2.2 (N=6)
Referred by outside agency, because of handicap	26.0 (N=70)
Enrolled through normal recruitment/ child find activities	53.5 (N=144)
Enrolled through special recruitment/ child find activities	3.3 (N=9)
Parent referred/other siblings previously in Head Start	14.9 (N=40)
Total**	100 (N=269)

TABLE 5.2

Agencies That Referred Sample Children to Head Start Programs 1/

Agency	% of Total
Private Practitioner/Consultant	6.6 (N=5)
Public Hospital	9.1 (N=7)
Public or State Health Department	9.2 (N=7)
Social Services Department	17.2 (N=13)
Public School System	18.4 (N=14)
Easter Seals Agency	2.6 (N=2)
Crippled Children's Association	3.9 (N=3)
BEH First Chance Project	1.3 (N=1)
University Affiliated Facility	5.3 (N=4)
Other	26.3 (N=20)
Total	100.0 (N=76)

1/ Includes only children who were referred by an outside agency (N=76).

(18.2%) of the referrals while social service departments referred 13 children (16.9%). However, other miscellaneous agencies accounted for 21 (27.2%) of the referrals.

The manner in which children came to the attention of Head Start programs varies by the severity of a child's disability and by program size. As Table 5.3 indicates, the proportion of children referred by outside agencies due to their handicaps increases as the severity of the handicap increases from mild to profound. Also, the proportion of children enrolled through normal recruitment/child find activities decreases with increasing handicap severity. That is, Head Start programs tended to identify proportionately more mildly and moderately impaired children through their normal recruitment activities, and proportionately more severely and profoundly impaired children were referred by outside agencies. The same type of trend is related to program size (see Table 5.4). That is, the smaller programs (1-400 children) depended proportionately more on referrals from outside agencies than did the larger programs (over 400 children), and the larger programs enrolled proportionately more children as a result of normal recruitment/child find activities.

Competition With Other Agencies For Enrollment[1]

The issue of competition between Head Start and other community agencies that serve handicapped children is important because, increasingly, all public preschool programs are being required to enroll and/or are receiving incentives for enrolling handicapped children. Specifically, Head Start programs are required to enroll a minimum of 10 percent handicapped children. Similar guidelines that apply to other public preschool programs include:

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[1] These data are program-specific.

TABLE 5.3

Manner in Which Children Came to the Attention of Head Start Programs by Severity Levels

	Severity Level					
Manner of Recruitment	Not Specified % of Column	Mild % of Column	Moderate % of Column	Severe % of Column	Profound % of Column	Not Relevant % of Column
Total**	100 (N=5)	100 (N=61)	100 (N=111)	100 (N=73)	100 (N=7)	100 (N=12)
Referred by outside agency, not because of handicap	*	1.6 (N=1)	3.6 (N=4)	1.4 (N=1)	*	*
Referred by outside agency, because of handicap	40.0 (N=2)	13.1 (N=8)	20.7 (N=23)	38.4 (N=28)	57.1 (N=4)	41.7 (N=5)
Enrolled through normal recruitment/child find activities	60.0 (N=3)	57.4 (N=35)	56.8 (N=63)	49.3 (N=36)	14.3 (N=1)	50.0 (N=6)
Enrolled through special recruitment/child find activities	*	3.3 (N=2)	1.8 (N=2)	2.7 (N=2)	28.6 (N=2)	8.3 (N=1)
Parent referred/other siblings previously in Head Start	*	24.6 (N=15)	17.1 (N=19)	8.2 (N=6)	*	*

TABLE 5.4

Manner in Which Children Came to the Attention of Head Start Programs by Program Size

Manner of Recruitment	Program Size				
	Not Specified % of Column	1-200 Children % of Column	201-400 Children % of Column	401-1000 Children % of Column	Over 1000 Children % of column
Total**	100 (N=14)	100 (N=36)	100 (N=78)	100 (N=46)	100 (N=95)
Referred by outside agency, not because of handicap	*	5.6 (N=2)	2.6 (N=2)	2.2 (N=1)	1.1 (N=1)
Referred by outside agency, because of handicap	28.6 (N=4)	38.9 (N=14)	30.8 (N=9)	19.6 (N=9)	20.0 (N=19)
Enrolled through normal recruitment/child find activities	64.3 (N=9)	44.4 (N=16)	43.6 (N=34)	69.6 (N=32)	55.8 (N=53)
Enrolled through special recruitment/child find activities	*	*	1.3 (N=1)	*	8.4 (N=8)
Parent referred/other siblings previously in Head Start	7.1 (N=1)	11.1 (N=4)	21.8 (N=17)	8.7 (N=4)	14.7 (N=14)

- If a State has public programs for preschoolers, PL 94-142 requires that handicapped children be served in those programs with normal children to the maximum extent possible. Further, by 1980, all State Education Agencies will be required to provide a free appropriate education to all handicapped individuals between the ages of 3 and 21,[1] which will increase the number of preschool programs that will be required to enroll handicapped children.
- Many states disperse funding for special educational programs based, in part, on the number of handicapped children in the program.

In light of these facts, it was expected that Head Start programs would experience competition with other agencies as they attempted to enroll handicapped children.

Over half of the programs in the sample reported that they did not compete with other agencies to enroll handicapped children (52.5%). However, 11 programs had experienced conflict with other agencies (18.6%) and 17 programs (28.8%) which had not experienced conflict over a particular child indicated that the possibility for conflict existed (see Table 5.5).[2] As Table 5.6 indicates, most of the programs that had experienced conflict or anticipated potential conflict (N=28) identified the public schools as the primary conflicting agency (71.4%). Other agencies identified as potential competitors included other private categorical programs (28.6%) and other private non-categorical programs (21.4%). Of the programs that had experienced conflict or anticipated

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[1] Unless this is inconsistent with State law or any court decision.

[2] Since it was expected that program staff would be reluctant to admit to direct conflict with other agencies, a response of "potential conflict" was considered to be indicative to conflict as well, and the two categories are combined for purposes of subsequent analyses.

TABLE 5.5

Head Start Programs That Competed With Other Agencies to Enroll a Particular Child	
Competition	% of Total
Yes	18.6 (N=11)
No, but the possibility for conflict exists	28.8 (N=17)
No	52.5 (N=31)
Total**	100 (N=59)

TABLE 5.6

Agencies With Whom Head Start Does or May Potentially Compete	
Agency	% of Total [1]
Public Schools	71.4 (N=20)
Easter Seal	7.1 (N=2)
University Affiliated Program	3.6 (N=1)
Other Private Categorical Program	28.6 (N=8)
Other Private Non-Categorical Program	21.4 (N=6)
State Institution	7.1 (N=2)
Other Head Start Program	7.1 (N=2)
Other	17.8 (N=5)

[1] Percentages are based on a total of 28 programs that indicated they had competed or may potentially compete with other agencies over enrollment of a specific handicapped child. Some programs indicated more than one agency.

potential conflict, the primary reason given for conflict was that the competing program served the same geographic area as the Head Start program (75.0%) (see Table 5.7). *The second most frequently cited reason for conflict involved disputes over the most appropriate placement for the child to obtain services (46.4%). Seven programs, however, indicated that conflicts were a result of funding considerations.*

TABLE 5.7

Reasons for Actual or Potential Conflict Over Enrollment

Reason	% of Total [1/]
Dispute Over Most Appropriate Placement for Services	46.4 (N=13)
Dispute Over Obtaining Children for Funding	25.0 (N=7)
Serve Same Geographic Area	75.0 (N=21)
Other	10.7 (N=3)

[1/] Percentages are based on a total of 28 programs that indicated they had competed or may potentially compete with other agencies over enrollment of a specific handicapped child. Some programs indicated more than one reason.

Despite the relatively small proportion of programs that experienced actual or potential conflict, experiences in the field and the conflicts related by program staff to the interviewers suggest that conflict between Head Start and other agencies, especially the public schools, may be a serious problem. For example, at least two programs spontaneously related their conflict experiences to field staff. In both cases, Head Start and the public schools were each attempting to identify and enroll handicapped children to meet specific program goals and competition ensued over the same group of handicapped children. In one case, pooling resources and cooperating in efforts to identify handicapped children allowed the competing agency to, in the words of Head Start staff, "pirate away" the handicapped children they had screened, diagnosed, and prepared for program entry. Furthermore, in the same case, the handicapped children were mainstreamed in the Head Start program but the competing agency placed the children in a self-contained setting, which was not the least restrictive placement available to the child. Such a placement does not reflect a child-centered approach to services; rather, political realities encouraged an agency-centered approach. Agency "turf" was more important than the most appropriate placement for the child primarily because each agency was struggling to obtain a sufficient number of handicapped children to meet funding guidelines.

Although only two programs chose to relate such detailed experiences to the interviewers, field staff observed other, more subtle indications of competition[1/] in additional programs. It is expected that this problem was occurring in other programs, and the problem may become more severe as greater numbers of programs are required to identify and enroll handicapped children, especially as the requirements of P.L. 94-142 become increasingly comprehensive over the next few years.

Despite the interagency competition issue, though, of the 269 handicapped children in the study sample who became enrolled in Head Start programs, Head Start personnel, the child's parents, and the child's diagnosticians agreed on the placement of the child in Head Start as opposed to other available programs in 264 cases (98.1%). This group, of course, does not include any handicapped children whose parents considered Head Start placement but finally chose another program, nor is there any indication of whether the parents of the sample Head Start children were aware of other placement possibilities.

[1/] Usually in the form of casual remarks made to field staff.

Entrance Requirements

The Head Start, Economic Opportunity, and Community Partnership Act of 1974 requires that, within each State, 10 percent of the children enrolled in Head Start must be handicapped. There are additional considerations involved in recruitment activities: the Head Start Program Performance Standards require that children should be recruited from the most disadvantaged homes, although each program is allowed to enroll 10 percent of its children from above-income guidelines homes, and recruitment activities are to be coordinated with other community agencies.

Almost all of the Head Start programs in the sample (96.5%) had a chronological age requirement for program entry (see Table 5.8). Almost half of the programs (44.1%) required that entering handicapped children's families must meet an income guideline. *While few other entrance requirements were widely established among the sample visited, it should be noted that at least 12 to 15 percent of the programs had requirements which precluded the enrollment of severely handicapped children, particularly those that had physical impairments. Eight programs required enrollees to be toilet trained, nine required enrollees to be ambulatory, and 13 restricted the enrollment of severely disabled children.*

As was noted in the introduction, each Head Start program is allowed to enroll as many as 10 percent of their children from families above income guidelines, and at least 10 percent of the enrolled children within each State must be handicapped. Table 5.9 shows the percentage of the programs' enrollment that consisted of children who were both handicapped and from above income guidelines familes. In almost half of the programs (47.5%), this group comprised less than one percent of the enrolled children. Furthermore, few of the programs (13.6%) enrolled five percent or more of their children from this group. *Most of the programs, then, enrolled few handicapped children who were also above income, although a small, but significant, number of programs filled all or almost all of their above-income openings with handicapped children.*

TABLE 5.8

Requirement	% of Total [1]
Chronological Age	96.6 (N=57)
Certain Handicapping Condition	15.3 (N=9)
Certain Severity Level	22.0 (N=13)
Ambulatory	15.3 (N=9)
Toilet Trained	13.6 (N=8)
Functioning at Minimum Developmental Level	15.3 (N=9)
Parental Commitment to Participate in Program	13.6 (N=8)
Must Meet Income Guidelines	44.1 (N=26)
Other	23.7 (N=14)

Entrance Requirements for Head Start Enrollment of Handicapped Children

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[1] Percentages are based on a total of 59 programs. Programs could indicate more than one requirement.

TABLE 5.9

Percentage of Head Start Programs' Enrollment Filled by Handicapped and Above-Income Guidelines Children	
Percentage of Enrollment	% of Total
None	27.2 (N=16)
Less than 1.00 percent	20.3 (N=12)
1.00 - 2.99 percent	22.0 (N=13)
3.00 - 4.99 percent	16.9 (N=10)
5.00 - 9.99 percent	8.5 (N=5)
10.00 percent and above	5.1 (N=3)
Total	100.0 (N=59)

Non-Head Start Program Entry

Data were collected on the recruitment procedures typically used in non-Head Start programs and the agencies that refer children for placement in the non-Head Start programs. These data are program-specific.

Non-Head Start Recruitment Procedures

Non-Head Start staff were asked to indicate the types of recruitment procedures they typically relied upon for purposes of enrolling handicapped children. Most frequently, the programs relied on a dual approach (34.8%): they conducted their own outreach and child find activities but also received referrals from a network of the other community agencies of which they were a part (see Table 5.10). Second most frequently, the programs enrolled handicapped children solely as a result of their involvement in an established community referral system (28.3%). Nine programs (19.6%) primarily recruited children through their own outreach and child find activities, and 5 programs (10.9%) did not rely on recruitment procedures but rather enrolled children as a result of parent application. On the basis of these data, *it appears that the non-Head Start programs typically depended on referrals from other community agencies to a much larger extent than Head Start programs. Since Head Start appears to identify more children as a result of recruitment/child find activities (albeit the same procedures used to recruit normal children), Head Start probably also identifies more children with handicaps who would otherwise have gone unserved than do non-Head Start programs. Non-Head Start programs seemed to enroll proportionately more children with previously-confirmed handicaps than did Head Start programs.*

Agencies That Referred Children to Non-Head Start Programs

Non-Head Start programs frequently received referrals from a variety of outside agencies (see Table 5.11). However, since these data are program-specific and the Head Start data are child-specific, the data are not directly comparable.

TABLE 5.10

Recruitment Procedures of Non-Head Start Programs	
Recruitment Procedure	% of Total
No recruitment procedure, enrollment based on parent application	10.9 (N=5)
Have own outreach and child find activities	19.6 (N=9)
Part of established community referral system	28.3 (N=13)
Part of established community referral system and have own outreach and child find activities	34.8 (N=16)
Other	6.5 (N=3)
Total**	100 (N=46)

TABLE 5.11

Agencies That Have Referred Handicapped Children for Placement in Non-Head Start Programs

Agency	% of Total[1]
Private Practitioner/Consultant	80.4 (N=37)
Public Hospital	58.7 (N=27)
Public/State Health Department	76.1 (N=35)
Social Service Department	87.0 (N=40)
Public School System	89.1 (N=41)
Easter Seal Agency	28.3 (N=13)
Crippled Children Association	43.5 (N=20)
Association for Retarded Children	47.8 (N=22)
BEH First Chance Project	10.9 (N=5)
University Affiliated Facilities	39.1 (N=18)
Head Start Program	56.5 (N=26)
Other	43.5 (N=20)

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[1] Percentages are based on a total of 46 non-Head Start programs. Programs were allowed to indicate more than one referring agency.

The three agencies from which non-Head Start programs most frequently received referrals were public school systems (41 programs), social services departments (40 programs), and private practitioners/consultants (37 programs). In comparison, private practitioners/consultants did not refer a large portion of the sample handicapped children to Head Start programs. This finding would seem to support the assumption that non-Head Start programs enroll more children with previously-diagnosed handicaps than do Head Start programs.

Non-Enrolled Children[1]

In general, Head Start programs enrolled most of the handicapped children that were brought to their attention. Programs in urban areas were more likely to have waiting lists; 12 programs, or 66.7 percent of all programs unable to enroll children, were in urban areas (see Table 5.12). Put another way, 50 percent of the urban programs had a handicapped waiting list whereas only 24 percent of the rural programs had a waiting list.

Twenty of the 59 programs indicated that they could not enroll all of the handicapped children they identified,[2] and Table 5.13 outlines the reasons programs could not enroll these children. Over half of these 20 programs indicated they had no available openings. The second most frequent reason for non-enrollment, however, was that the children did not meet income guidelines[3] (45.0%). Only one program with a waiting list felt that the attendance of the child would be detrimental to others and only one program could not enroll handicapped children due to inadequate facilities. *These data indicate that Head Start programs, in general, are willing to place handicapped*

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[1] Most of the data in this section are program-specific.

[2] Although 20 programs could not enroll all the handicapped children, fewer programs (18) had a waiting list. The children who were not enrolled in the other two programs were placed in other preschool settings.

[3] That is, their families' annual income was above the maximum allowed by Head Start.

TABLE 5.12

Distribution of Urban or Rural Programs with a Waiting List by Program Size

Program Location	Program Size				Number of Programs with no Waiting List
	1-200 children % of Column	201-400 children % of Column	401-1000 children % of Column	over 1000 children % of Column	
Total	100.0 (N=5)	100.0 (N=7)	100.0 (N=2)	100.0 (N=4)	N=41
Urban	60.0 (N=3)	57.1 (N=4)	50.0 (N=1)	100.0 (N=4)	N=12
Rural	40.0 (N=2)	42.9 (N=3)	50.0 (N=1)	*	N=25
Not Specified[1/]	*	*	*	*	N=4

[1/] This category includes 3 Indian and 1 migrant program.

TABLE 5.13

Reasons Why Head Start Programs Were Unable to Enroll Handicapped Children

Reason	% of Total[1]
Did not meet income guidelines	45.0 (N=9)
No available openings	55.0 (N=11)
Lack of suitable facilities and/or equipment	5.0 (N=1)
Other agencies serve these children	30.0 (N=6)
Handicap too severe	20.0 (N=4)
Felt child's attendance would be detrimental to others	5.0 (N=1)
Child's parent refused	40.0 (N=8)
Lack of adequate transportation	35.0 (N=7)
Other	45.0 (N=9)

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[1] Percentages are based on a total of 20 programs that were unable to enroll all the handicapped children they identified. Programs could indicate more than one reason.

children in a setting with normal children and that the main obstacles to enrolling these children are already optimum enrollments and failures to meet income guidelines.

Referrals to Other Programs

Seventeen of the 59 sample programs (28.8%) indicated that they referred non-enrolled children to other programs in the area. The breakdown of these programs by location and size is given in Table 5.14. In contrast to programs with waiting lists, over half of those that referred children were located in rural areas (52.9%).

Table 5.15 shows the agencies to which referrals were most often made. Over half of the 17 programs making referrals (58.8%) indicated that children were sent to the public schools. Seven programs referred handicapped children to private categorical programs, but only 3 programs made referrals to private non-categorical programs. This would indicate that almost half of the referrals made by Head Start were done so that children could receive even more specialized services for their handicapping conditions, although the children enrolled in categorical programs were not placed in a mainstreaming setting.

Characteristics of Non-Enrolled Children

Head Start programs were asked to supply information on the number and types of handicapped children that were on waiting lists for their programs. Approximately 221[1] handicapped children were on waiting lists for enrollment in 18 Head Start programs. (See Table 5.16). Speech impaired children were most frequently represented among this group (35.8%). There were no blind children on the waiting lists of the sample programs and only one deaf child.

Alternately, 17 Head Start programs indicated that they had referred a total of 96 children who were not enrolled in their program

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[1] This number is somewhat misleading since one program had over 100 children on its waiting list. The other 17 programs with waiting lists, then, generally had only a few children on their respective waiting lists.

TABLE 5.14

Programs that Referred Non-Enrolled Children to Other Agencies by Program Size and Location

Program Location	Program Size					
	1-200 Children % of Column	201-400 Children % of Column	401-1000 Children % of Column	Over 1000 Children % of Column	Not Specified % of Column	Number of Programs that have not Referred Children
Total	100.0 (N=5)	100.0 (N=5)	100.0 (N=2)	100.0 (N=4)	100.0 (N=1)	N=42
Urban	20.0 (N=1)	60.0 (N=3)	* (N=0)	75.0 (N=3)	*	N=17
Rural	80.0 (N=4)	40.0 (N=2)	100.0 (N=2)	25.0 (N=1)	*	N=22
Indian/Migrant Programs					100.0 (N=1)	N=3

TABLE 5.15

Agencies To Which Non-Enrolled Children Were Referred	
Agency	% of Total[1]
Public Schools	58.8 (N=10)
Easter Seal	29.4 (N=4)
Association for Crippled Children	29.4 (N=5)
Other Private Categorical Program	41.2 (N=7)
Other/Private Non-Categorical Program	17.6 (N=3)
State Institution	23.5 (N=4)
Other Head Start Program	41.2 (N=7)
Other	41.2 (N=7)

[1] Percentages are based on a total of 17 Head Start programs that referred non-enrolled children to other agencies. Programs were allowed to indicate more than one agency.

TABLE 5.16

Distribution of Types of Handicapped Children Not Able to Enroll in Head Start

Handicapping Condition	% of total
Blind	*
Visually Impaired	2.7 (N=6)
Deaf	0.5 (N=1)
Hearing Impaired	4.1 (N=9)
Physical Handicap	6.9 (N=15)
Speech Impaired	35.8 (N=86)
Health or Developmentally Impaired	15.8 (N=35)
Mentally Retarded	9.5 (N=21)
Serious Emotional Disturbance	18.1 (N=40)
Specific Learning Disability	3.6 (N=8)
Total**	100 (N=221)

to other community agencies/programs. Tables 5.17 and 5.18 show the types of handicapped children referred and the severity level of handicapped children referred, respectively.

The greatest number of the 96 children referred were those with speech impairments (25.0%), which is consistent with the more frequent occurrence of this type of handicapping condition in the general population. Of secondary and tertiary frequency of referral were the seriously emotionally disturbed (15.6%) and mentally retarded (12.5%). These same two categories comprised the two highest occurrences of the severely handicapped children referred to other programs (Table 5.18).

Stated another way, of the 12 mentally retarded children referred to other programs, 11 were severely handicapped; of the 15 seriously emotionally disturbed children referred, 10 were severe cases. These two handicapping conditions account for just under one half (47.7%) of all severely handicapped children referred to other programs rather than enrolled in Head Start.

The Head Start programs with waiting lists supplied field interviewers with the names of two to three children on their waiting lists, and the field staff then attempted to contact and interview the parents of these children. Information on a total of 13 non-enrolled handicapped children was obtained in this manner.[1]

Six types of handicapping conditions were represented by the 13 non-enrolled cases on whom data were collected, with the largest number (5) occurring in the area of speech impairment. There were two cases each of health impairment and multiple handicaps, and one case each of visual impairment, physical handicap, and serious emotional disturbance. More than half of the 13 non-enrolled children were not enrolled in any other type of program. However, several

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[1] Field staff encountered a great deal of difficulty in completing interviews with parents of non-enrolled children due to non-response, refusals, etc. This accounts for the small number of cases (N=13) in the sample of handicapped children on Head Start waiting lists.

TABLE 5.17

Type of Handicapped Children Referred to Other Programs by Head Start

Handicapping Condition	% of Total
Blind	2.1 (N=2)
Visually Impaired	2.1 (N=2)
Deaf	*
Hearing Impaired	11.5 (N=11)
Physical Handicap	8.3 (N=8)
Speech Impaired	25.0 (N=24)
Health or Developmentally Impaired	9.4 (N=9)
Mentally Retarded	12.5 (N=12)
Serious Emotional Disturbance	15.6 (N=15)
Specific Learning Disability	1.0 (N=1)
Other	12.5 (N=12)
Total**	100 (N=96)

TABLE 5.18

Type of Severely Handicapped Children Referred to Other Programs by Head Start

Handicapping Condition	% of total
Blind	4.5 (N=2)
Visually Impaired	2.3 (N=1)
Deaf	*
Hearing Impaired	4.5 (N=2)
Physical Handicap	13.6 (N=6)
Speech Impaired	15.9 (N=7)
Health or Developmentally Impaired	9.1 (N=4)
Mentally Retarded	25.0 (N=11)
Serious Emotional Disturbance	22.7 (N=10)
Specific Learning Disability	2.3 (N=1)
Other	*
Total**	100 (N=44)

kinds of special services were provided as a result of contact with Head Start. Medical or dental treatment was provided in five cases through Head Start contact. Head Start was also instrumental in arranging for services for the sample of non-enrolled children, including the provision of day care, educational instruction, family counseling and therapy (other than occupational or physical therapy).[1]

Program Termination[2]

Head Start programs are expected to provide comprehensive services to handicapped children in a mainstream setting. The frequency of and reasons for children's termination from the programs are important insofar as they indicate potential barriers to this goal. That is, an examination of the conditions surrounding termination will help determine if the Head Start programs are encountering problems in providing appropriate services to the children.

Tables 5.19 and 5.20 show the reasons for parent-initiated and center-initiated terminations, respectively. A little over half of the 59 programs reported only small numbers of children (1-5) who left the program voluntarily. Only 14 programs reported center-initiated termination of handicapped children; again, the majority indicated that this occurred only with a small number of children (1-5 per program).

The major reason for parent-initiated withdrawal of children was that the family moved. A total of 31 programs reported that this occurred; 28 programs (47.1%) indicated that this happened only for a few children (1-5); 1 program (1.7%) for 6-10 children; and two programs indicated that over 10 children withdrew from Head Start due to a family move. The second major reason for parent-initiated withdrawal was that the child transferred to another program. Eleven programs had a few (1-5) children that transferred; two other programs indicated that this occurred in six or more cases.

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[1] These services were home-based.

[2] These data are program-specific.

TABLE 5.19

Conditions of Parent-Initiated Termination from Head Start Programs

Number of Children Terminated	Conditions of Termination					
	Moved % of Column	Parental Dissatisfaction With Program % of Column	Child No Longer Needed Program % of Column	Child Transferred to Another Program % of Column	Unknown % of Column	Total of Programs With Voluntary Withdrawals % of Column
Total**	100 (N=59)	100 (N=59)	100 (N=59)	100 (N=59)	100 (N=59)	100 (N=59)
1-5 Children	47.1 (N=28)	8.5 (N=5)	5.1 (N=3)	18.6 (N=11)	8.5 (N=5)	44.1 (N=26)
6-10 Children	1.7 (N=1)	*	1.7 (N=1)	1.7 (N=1)	*	5.1 (N=3)
Over 10 Children	3.4 (N=2)	*	*	1.7 (N=1)	*	3.4 (N=2)
None/no response	47.5 (N=28)	91.5 (N=54)	93.2 (N=55)	78.0 (N=46)	91.5 (N=54)	47.5 (N=28)

TABLE 5.20

Conditions of Center-Initiated Termination from Head Start Programs

Number of Children Terminated	Conditions of Termination					
	Classroom Management Difficulties % of Column	Age Ineligible % of Column	Entrance into Public School-Special Class % of Column	Inability of Staff to Deal With Handicap % of Column	Entrance into Other Service Program % of Column	Total of Programs With Center Terminations % of Column
Total **	100 (N=59)	100 (N=59)	100 (N=59)	100 (N=59)	100 (N=59)	100 (N=59)
1-5 Children	1.7 (N=1)	8.5 (N=5)	13.6 (N=8)	5.1 (N=3)	16.9 (N-10)	15.3 (N=9)
6-10 Children	*	*	5.1 (N=3)	*	1.7 (N=1)	3.4 (N=2)
Over 10 Children	*	1.7 (N=1)	11.9 (N=7)	*	*	5.1 (N=3)
None/no response	98.3 (N=58)	89.8 (N=53)	69.7 (N=41)	94.9 (N=56)	81.4 (N=48)	76.3 (N=45)

The major reason for center-initiated termination of handicapped children was entrance into the public school system. Of the 59 sample programs, 8 (13.6%) indicated this occurred for 1-5 children in their programs; 3 (5.1%) programs lost 6-10 children in this manner; and 7 programs (11.9%) reported that over 10 children left their programs to enter the public school system. Of secondary frequency, children entered other service programs and were thus terminated by Head Start. Out of 59 programs, this reason was reported by 10 programs (16.9%) as involving 1-5 of their pupils and one other program (1.7%) reported 6-10 children entering other service programs. In general, then, center-initiated termination did not result in a complete withdrawal of services, but rather was initiated basically as a means to change or improve the services received by handicapped children. Only one program (1.7%) indicated classroom management difficulties as the reason for center-initiated termination and three programs discontinued children because their staffs were unable to deal with particular handicaps. In both of these cases, however, the numbers of children affected were small (1-5 cases).

Approximately three-quarters of the programs (76.3%) indicated they conducted follow-up activities in order to ensure continuity of service for the children who left their programs. The nature of the follow-up activities was unspecified. Follow-up activities will be investigated more systematically during the second phase of this study.

Summary of Findings

- Head Start programs reported the use of some type of outreach/recruitment activity to identify handicapped children, but the sample handicapped children were predominantly enrolled as a result of the outreach/child find activities conducted for normal children. It appears that few Head Start programs used outreach/child find activities specifically targeted at handicapped children, but rather identified handicapped children from the group of economically disadvantaged children they identified through normal procedures.

- Less than half of the Head Start programs indicated actual or potential conflict with other agencies in efforts to enroll handicapped children. However, informal observations of field staff indicated that the problem may be more pervasive than it was reported to be.

- About one-quarter of the sample handicapped children were referred for Head Start enrollment by other community agencies, and about one-quarter of the Head Start programs referred handicapped children they were unable to enroll to other programs in the community.

- Few Head Start programs imposed entrance requirements beyond the two established by the Administration for Children, Youth and Families (age and income eligibility). In about half of the programs, less than one percent of the programs' enrollments were comprised of handicapped children who were also from above-income families. In a few programs, however (about 15%), half to all of the programs' above-income openings were filled by handicapped children.

- About one-third of the Head Start programs were unable to enroll all of the handicapped children they had identified. Reasons were primarily lack of openings, but slightly less than half of the programs with non-enrolled handicapped children had been unable to enroll the children because they were from above-income families. A few programs were unable to enroll handicapped children for reasons related to a child's handicap. However, most of the programs that were unable to enroll handicapped children referred them to other programs/agencies in the community, primarily to the public schools or private categorical programs.

- Non-Head Start programs did not often solely rely on their own outreach/child find activities to identify and enroll handicapped children. About one-third of the programs used a dual approach: they depended on referrals from other agencies and also conducted outreach/recruitment activities. About one-quarter of the programs enrolled handicapped children solely as a result of referrals. From these data, it appears that non-Head Start programs primarily enrolled children who were referred to them because of their handicaps, whereas Head Start primarily identified handicapped children for enrollment from the group of children they identified through normal recruitment procedures.

- Slightly more than half of the Head Start programs had experienced voluntary withdrawals of handicapped children, mostly involving small numbers of children. The primary reason was that the family moved. About one-quarter of the programs had themselves terminated handicapped children, mostly because the children entered the public school system or other programs of service. Finally, three-quarters of the programs indicated that they conducted follow-up activities for the children who left their program.

6

SCREENING SERVICES

Screening, a process that identifies children with potential handicaps, is the first step in a series of procedures that Head Start programs utilize for the purpose of identifying, evaluating, and serving children with special needs. Screening is provided to all Head Start children, although diagnostic services (consisting of confirmation of and a functional assessment related to the suspected handicap and recommendations for services) are delivered only to those children identified as "at risk" as a result of screening procedures. This group includes some children that further testing will reveal as functioning within normal limits and some children that further testing will confirm as handicapped. Screening, then, is the process by which children who may have potential handicaps or problems are targeted for an in-depth diagnostic evaluation. However, screening results are not sufficient, in and of themselves, to determine whether a child should be labeled as handicapped.

As stated in the Head Start Program Performance Standards[1] each Head Start child shall be provided "... a thorough health screening..." Furthermore, this screening "... should be completed within 90 days after the child is enrolled or entered into the program...." The Standards go on to indicate several areas in which Head Start children must be screened, including vision, hearing, speech and language, physical coordination and development, intellectual development, and social/emotional development.

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[1] OCD-HS Head Start Policy Manual, OCD Notice N-30-364-4, DHEW, July 1976. The 90-day time frame for completion of screening services is a guideline and not a program requirement.

This chapter describes the screening services that were received by the 269 handicapped children included in the study sample. These services are compared to those generally received by children in non-Head Start programs. The following screening-related questions are examined in the context of this chapter[1]:

- How complete are the screening services provided by Head Start to the sample handicapped children? In what areas were the sample children predominantly screened?
- Was complete screening provided to the sample Head Start children within 90 days of program entry, as suggested in the Head Start Program Performance Guidelines?
- Who provided screening services to the sample Head Start children? With what agencies were the screening providers affiliated? Who paid for screening services?
- What techniques were used to screen the sample Head Start children in each screening area?
- How frequently did screening results indicate potential handicaps, including secondary handicaps, for the sample Head Start children? Did screening results indicate potential handicaps in the areas in which the sample children were later determined to be primarily handicapped?
- How many of the sample Head Start children were confirmed as handicapped in the areas in which screening results indicated potential handicaps?
- What type of screening services did the non-Head Start programs typically provide to handicapped children? What professionals were used to provide screening services? With what agencies were they affiliated?
- What types of techniques did non-Head Start programs use to conduct screening in each of the six developmental areas?

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[1] All Head Start data are child-specific and all non-Head Start data are program-specific.

- How do the screening procedures typically used by the non-Head Start programs compare to the screening services received by the sample of Head Start handicapped children?

It is also important to note the types of screening issues not considered in this report. Since the screening services received by a group of children who were identified as handicapped were examined, it is outside of the scope of the study to describe the types of screening services or the efficiency of screening provided to all Head Start children - handicapped and non-handicapped alike. Data only permit an investigation of whether the appropriate sequence of screening and diagnostic services were provided to this group of children, given that the children were identified as handicapped. A direct determination of the quality or validity of screening and diagnostic procedures used in Head Start was beyond the scope of the study as well.

Head Start Screening Services

Completeness of Screening Services

According to the Head Start Program Performance Standards, all Head Start children should be screened in each of the six previously mentioned developmental areas.[1/] A child who is screened in each of these six areas through regular program screening procedures was considered to have received complete screening services. Screening in any additional areas and/or more in-depth screening in any of the six previously-mentioned regular areas constitutes additional screening. Some children may receive the regular screening services in fewer than the six basic areas; these children are considered to have received partial screening services. Finally, a child who is screened in fewer

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[1/] The standards, however, do not contain a clear statement of screening requirements for ascertaining potential handicaps in areas other than those that are health-related. The discussion of health standards covers vision and hearing screening and physical development, while the other three areas are mentioned in the section of the program standards related to mental health objectives.

than the six standard areas but who also receives additional screening is considered to have received partial plus additional screening. Keeping these definitions in mind, Table 6.1 presents the number of children who received each of the four configurations of screening services, according to staff report.

Program staff indicated that 49 of the handicapped children in the study sample (18.2%) received complete screening services as specified under Head Start Performance Standards, and an additional 87 children (32.3%) received complete screening services plus additional screening.[1] *Thus, according to staff reports, a total of 50.5 percent of the handicapped children in the sample received complete screening services as specified by the Performance Standards.* Partial screening or partial plus additional screening was reported for 118 children (43.8%) and no screening services were reported[2] for 15 children (5.6%).

Data were also examined concerning the proportion of children who were screened in each of the six specified areas (see Table 6.2). *Vision and hearing were the areas in which children were most frequently screened (84.4 and 87.0% respectively), while the fewest number of children were screened in the areas of intellectual development and social/emotional development (70.1 and 68.0%, respectively).* The relatively lower proportion of children screened for intellectual and social/emotional problems may be due to the fact that the screening

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[1] This distribution varies by program location (see Table A6.1, Appendix A); 57.1 percent of the children who received complete screening were enrolled in rural programs and 32.9 percent of the children who received complete plus additional screening were enrolled in rural programs. Thus, rural programs reported the use of more complete screening procedures than urban programs.

[2] This figure includes children who were not screened as well as children for whom the screening services were not reported or recorded.

TABLE 6.1

Completeness of Screening Services Provided to the Head Start Sample Children	
Completeness of Screening	% of Total
No screening services reported	5.6 (N=15)
Complete screening as specified under Head Start Performance Standards	18.2 (N=49)
Complete screening as specified under Head Start Performance Standards plus additional screening services	32.3 (N=87)
Partial screening	24.5 (N=66)
Partial screening plus some additional screening	19.3 (N=52)
Total**	100 (N=269)

TABLE 6.2

Proportion of Sample Children Screened in Each Screening Area	
Area Screening	% of Total[1/]
Vision	84.4 (N=227)
Hearing	87.0 (N=234)
Physical Coordination and Development	76.2 (N=201)
Speech and Language	76.6 (N=206)
Intellectual Development	70.1 (N=191)
Social/Emotional Development	68.0 (N=183)

[1/] A total percentage was not computed since children could be screened in more than one area. Percentages are based on the sample of children (N=269).

requirements for these areas are not clearly defined in the Head Start Performance Standards (see f.n., p. 6.3).

Time of Screening Completion

In order for children to receive services appropriate to their special needs during the program year, the children with special needs must be identified (i.e., screened and diagnosed) early in the program year. The Performance Guidelines suggest that screening should be completed within 90 days, or three months, of program entry. This guideline was, of course, met for those children who were screened prior to program entry (24.9%; see Table 6.3). For those children who were screened following enrollment (N=172), Table 6.4 presents the distribution of the study sample by the latest month in which screening was conducted.[1] Screening for 109 of these 172 children (63.4%) was conducted prior to January, or within three months of program entry (81% of the sample children were enrolled by the end of September and an additional 9.5%, or a total of 90.3%, were enrolled by the end of October). Screening for 31 children (18.0%) was conducted between January and May, and the date of the latest screening was not specified for 32 children (18.6%). *Therefore, including those children who were screened prior to enrollment, most of the sample children (65.4%) received at least partial screening within three months of program entry in accordance with the guidelines included in the Performance Standards.*

Table 6.5 provides similar data for those children who received complete screening services. Almost all of the children who received complete screening services were screened prior to January (69 or 86.3%), or within three months of program entry. *Thus, screening was conducted earlier in the program year for children who received complete screening services than for children who received partial screening services.*

Table 6.6 indicates the month of completion of regular screening for each screening area. This table considers only those children for whom screening was completed following enrollment. In five of the six

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[1] These data include children who did not receive complete screening. These data simply indicate the latest month in which some form of screening was conducted.

TABLE 6.3

Completion of Screening Prior to/After Enrollment in Head Start

When Screening is Completed	% of Total
No screening services reported	10.4[1] (N=28)
Prior to enrollment	24.9 (N=67)
After enrollment	63.9 (N=172)
Initiated prior to enrollment and completed after enrollment	0.7 (N=2)
Total**	100 (N=269)

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[1] Includes 15 children for whom no screening services were provided and 13 children referred to Head Start because of identified handicaps but for whom Head Start staff had no knowledge of screening services these children may have received.

TABLE 6.4

Latest Month Screening Conducted After Enrollment[1]

Month Screening Completed	% of Total
August, 1976	1.7 (N=3)
September, 1976	5.2 (N=9)
October, 1976	18.0 (N=31)
November, 1976	20.9 (N=36)
December, 1976	17.4 (N=30)
January, 1977	3.5 (N=6)
February, 1977	9.9 (N=17)
March, 1977	1.7 (N=3)
April, 1977	0.0 (N=0)
May, 1977	2.9 (N=5)
Not Specified [2]	18.6 (N=32)
Total**	100** (N=172)

[1] Includes only children for whom screening services were conducted after their date of enrollment (N=172). These data reflect the latest date screening was reported for sample children. These data, therefore, also include the latest date of screening for children who did not receive complete screening in accordance with Head Start Performance Standards.

[2] These children had received complete screening services, but the date of screening completion was not reported.

TABLE 6.5

Month of Screening Completion for Children
Who Received Complete Screening After Enrollment[1]

Month Screening Completed	% of Total
Prior to August, 1976	14.7 (N=14)
August - October, 1976	27.4 (N=26)
November, 1976 - January, 1977	44.2 (N=42)
February - April, 1977	9.5 (N=9)
After April, 1977	4.2 (N=4)
Total	100.0 (N=95)

[1] Does not include 41 children who received complete screening services that were, in part, provided by agencies other than Head Start (and not coordinated with the Head Start screening process).

TABLE 6.6

Month of Completion of Regular Screening[1] by Screening Area

	Regular Screening Area					
Month Screening Completed	Vision % of Column	Hearing % of Column	Physical Coordination and Development % of Column	Speech and Language % of Column	Intellectual Development % of Column	Social/ Emotional Development % of Column
Total**	100 (N=172)	100 (N=172)	100 (N=172)	100 (N=172)	100 (N=172)	100 (N=172)
Prior to August, 1976	12.2 (N=21)	15.1 (N=26)	15.1 (N=26)	15.1 (N=26)	12.8 (N=22)	12.8 (N=22)
August - October, 1976	39.0 (N=67)	33.8 (N=58)	34.3 (N=59)	40.7 (N=70)	40.7 (N=70)	36.0 (N=62)
November, 1976-January, 1977	26.2 (N=45)	38.4 (N=66)	29.1 (N=50)	23.2 (N=40)	19.2 (N=33)	18.0 (N=31)
February - April, 1977	9.9 (N=17)	1.7 (N=3)	2.9 (N=5)	1.2 (N=2)	1.8 (N=3)	5.8 (N=10)
After April, 1977	0.6 (N=1)	0.6 (N=1)	0.6 (N=1)	1.7 (N=3)	1.8 (N=3)	1.7 (N=3)
Not Specified/ Not Screened	12.2 (N=21)	10.5 (N=18)	18.0 (N=31)	18.0 (N=31)	23.8 (N=41)	25.6 (N=44)

[1] Including only sample children for whom screening was completed after enrollment (N=172)

areas (excluding hearing), screening was predominantly completed between August and October (ranging from 34.3 to 40.7% of the cases), and was secondarily completed between November and January (between 18.0 and 29.1%). In hearing, the order is reversed; hearing screening was predominantly completed between November and January (38.4%) and secondarily completed between August and October (33.8%). The relatively later time of completion of hearing screening may be due to the need for special equipment and difficulty in obtaining/scheduling the required equipment or services of specialists.

In summary, screening services for most of the children in the study sample were conducted prior to enrollment or within three months of program entry, in accordance with the Head Start Program Performance Guidelines (176, or 68.0%). However, complete screening was reported for only 50 percent of the entire sample.

Professional Providers Used for Screening Services

For most of the screening areas, screening was most frequently conducted by a specialist trained in that area[1] (see Table 6.7). Vision screening, for example, was most often conducted by a public health nurse (20.4%) or a medical professional (14.5%). An audiologist or speech therapist was most frequently used for hearing screening (35.7%). For physical coordination and development, the most frequently used screeners were medical professionals (29.4%) or Head Start staff (19.0%). Speech therapists or audiologists most frequently conducted speech and language screening (33.1%). Finally, however, Head Start staff were most frequently involved in screening in the areas of intellectual development and social/emotional development (45.4 and 40.9%, respectively).[2] The pattern of providers used for additional screening is much the same (see Table A6.2, Appendix A) except that

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[1] A specialist may have been on the Head Start staff in which case he/she was coded into the appropriate specialist category rather than as "Head Start staff."

[2] Observation techniques and diagnostic tests, which can be administered by Head Start staff who are trained to do so, were frequently used to screen in these areas.

TABLE 6.7

Type of Service Provider Who Performed Regular Screening in Each Screening Area

Screening Area	Total** % by Row	Not Reported % by Row	Psychologist/ Psychiatrist % by Row	Pediatrician/ Other Licensed Medical Professional % by Row	Speech Therapist/ Audiologist % by Row	Paraprofessional Medical Personnel % by Row	Social worker % by Row	Public Health Nurse % by Row	Interdisciplinary Team % by Row	Head Start Staff Teacher % by Row	Other % by Row
				Providers							
Vision	100 (N=269)	15.6 (N=42)	0.4 (N=1)	14.5 (N=39)	2.6 (N=7)	9.7 (N=26)	0.4 (N=1)	20.4 (N=55)	2.6 (N=7)	6.7 (N=18)	27.1 (N=73)
Hearing	100 (N=269)	13.0 (N=35)	*	8.6 (N=23)	35.7 (N=96)	7.8 (N=21)	*	15.2 (N=41)	4.8 (N=13)	1.9 (N=5)	13.0 (N=35)
Physical Coordination and Development	100 (N=269)	23.8 (N=68)	1.9 (N=5)	29.4 (N=79)	1.9 (N=5)	0.4 (N=1)	*	5.6 (N=15)	11.5 (N=31)	19.0 (N=51)	6.7 (N=18)
Speech and Language	100 (N=269)	23.4 (N=63)	2.6 (N=7)	5.6 (N=89)	33.1 (N=89)	1.1 (N=3)	*	2.2 (N=6)	8.9 (N=24)	19.3 (N=52)	3.7 (N=10)
Intellectual Development	100 (N=269)	29.5 (N=78)	7.4 (N=20)	3.7 (N=10)	3.3 (N=9)	*	0.4 (N=1)	2.2 (N=6)	5.2 (N=14)	45.4 (N=122)	3.3 (N=9)
Social/ Emotional Development	100 (N=269)	32.0 (N=86)	9.3 (N=25)	3.3 (N=9)	2.6 (N=7)	*	1.1 (N=3)	2.6 (N=7)	4.8 (N=13)	40.9 (N=110)	3.3 (N=9)

psychologists or psychiatrists are the primary providers of additional screening in intellectual development and social/emotional development (5.2 and 7.8%, respectively, of the total sample and 31.1 and 47.7%, respectively, of children who received additional screening in the areas). Furthermore, most of the agencies or professionals who were chosen for provision of screening services were selected because they were regularly used as part of the program's established screening network (see Table 6.8) as opposed, for example, to selection for a particular child. *It is apparent then, that, on a regular, established basis, the Head Start programs studied are often utilizing the services of professionals trained in areas relevant to the screening areas for a large portion of their screening services, even when these professionals have to be brought in from other agencies.*

Agency Affiliation of Service Providers

The individuals who provided screening services to Head Start handicapped children were most frequently employed by Head Start[1] regardless of screening area (see Table 6.9). The second most frequent agency affiliation of screening providers varies by screening area. Professionals affiliated with public or state health departments provided vision and hearing screening for 19.0 and 19.3 percent of the sample children, respectively. In the areas of physical coordination and development and speech and language, private practitioners or consultants provided screening to 14.9 and 12.6 percent of the sample, respectively. As Table 6.10 indicates, private practitioners/consultants, hospitals, or public school systems were most frequently used for provision of additional screening services. It is very noteworthy though, that providers affiliated with public

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[1] This group includes Head Start Staff without a specialty area (i.e., regular teachers, aides) as well as specialists (i.e., audiologists, psychologists) on the Head Start staff.

TABLE 6.8

Reason for Use of Agencies/Professionals for Regular Screening Services by Screening Area

Screening Area					Reasons				
	Total** % of Row	Not Reported % of Row	Least Expensive Service Available % of Row	Best Service Available % of Row	Only Service Available % of Row	Part of Established Screening Service with Which Program is Associated % of Row	Agency Used for This Particular Child-Screening Not Generally Provided to All Head Start Enrollees % of Row	No Choice in the Matter; Child Was Screened Prior to Referral % of Row	Other % of Row
Vision	100 (N=269)	15.6 (N=42)	8.6 (N=23)	9.7 (N=26)	6.3 (N=17)	56.9 (N=153)	0.7 (N=2)	1.9 (N=5)	0.4 (N=1)
Hearing	100 (N=269)	13.4 (N=36)	6.3 (N=27)	14.5 (N=39)	5.9 (N=16)	54.6 (N=147)	1.1 (N=3)	3.7 (N=10)	0.4 (N=1)
Physical Coordination and Development	100 (N=269)	23.8 (N=64)	7.8 (N=21)	14.9 (N=40)	3.7 (N=10)	39.8 (N=107)	2.6 (N=7)	5.6 (N=15)	1.9 (N=5)
Speech and Language	100 (N=269)	23.8 (N=64)	5.9 (N=16)	13.8 (N-37)	7.4 (N=20)	43.1 (N=116)	1.9 (N=5)	3.0 (N=8)	1.1 (N=3)
Intellectual Development	100 (N=269)	29.7 (N=80)	7.8 (N=21)	11.5 (N=31)	5.2 (N=14)	39.4 (N=106)	2.6 (N=7)	2.6 (N=7)	1.1 (N=3)
Social Emotional Development	100 (N=269)	31.2 (N=84)	5.9 (N=16)	10.4 (N=28)	5.2 (N=14)	42.0 (N=113)	1.5 (N=4)	1.9 (N=5)	1.9 (N=5)

TABLE 6.9

Agencies That Provided Regular Screening Services to Head Start by Screening Area

Screening Area	Agency										
	Total** % of Row	Not Reported % of Row	Private Practitioner/ Consultant % of Row	Hospital % of Row	Public or State Health Department % of Row	Social Services Department % of Row	Public School System % of Row	Easter Seal Agency % of Row	University Affiliated Facilities % of Row	Other % of Row	Head Start % of Row
Vision	100 (N=269)	16.0 (N=43)	8.2 (N=22)	1.5 (N=4)	19.0 (N=51)	0.7 (N=2)	7.1 (N=19)	*	1.9 (N=5)	10.8 (N=29)	34.9 (N=94)
Hearing	100 (N-269)	13.0 (N=35)	6.7 (N=18)	1.9 (N=5)	19.3 (N=52)	1.1 (N=3)	10.0 (N=27)	*	11.5 (N=31)	14.1 (N=38)	20.8 (N=56)
Physical Coordination and Development	100 (N=269)	23.0 (N=62)	14.9 (N=40)	4.1 (N=11)	10.0 (N=27)	0.7 (N=4)	1.5 (N=4)	*	3.0 (N=8)	11.5 (N=31)	31.2 (N=84)
Speech and Language	100 (N=269)	23.4 (N=63)	12.6 (N=34)	3.3 (N=9)	3.3 (N=9)	0.7 (N=2)	7.4 (N=20)	1.5 (N=4)	10.0 (N=27)	13.8 (N=37)	23.8 (N=64)
Intellectual Development	100 (N=269)	29.0 (N=78)	4.1 (N=11)	1.1 (N=3)	3.0 (N=8)	*	2.2 (N=6)	*	1.5 (N=4)	11.9 (N=32)	47.2 (N=127)
Social/ Emotional Development	100 (N=269)	30.9 (N=83)	5.6 (N=15)	1.1 (N=2)	3.3 (N=9)	0.4 (N=1)	1.1 (N=3)	*	1.5 (N=4)	8.6 (N=23)	47.6 (N=128)

TABLE 6.10

Agencies That Provided Additional Screening Services to Head Start by Screening Area

Screening Area	Agency									
	Total** % of Row	Not Reported % of Row	Private Practitioner/ Consultant % of Row	Hospital % of Row	Public or State Health Department % of Row	Public School System % of Row	Easter Seal Agency % of Row	University Affiliated Facilities % of Row	Other % of Row	Head Start % of Row
Vision	100 (N=269)	87.7 (N=236)	5.2 (N=14)	0.7 (N=2)	2.6 (N=7)	0.4 (N=1)	*	1.1 (N=3)	1.1 (N=3)	1.1 (N=3)
Hearing	100 (N=269)	79.6 (N=214)	5.9 (N=16)	9.7 (N=2)	4.1 (N=11)	0.7 (N=2)	2.6 (N=7)	2.2 (N=6)	3.3 (N=9)	0.7 (N=2)
Physical Coordination and Development	100 (N=269)	81.4 (N=219)	3.7 (N=10)	1.9 (N=5)	1.9 (N=3)	2.2 (N=6)	*	2.2 (N=6)	4.1 (N=11)	3.3 (N=9)
Speech and Language Development	100 (N=269)	72.5 (N=195)	4.5 (N=12)	0.4 (N=1)	0.4 (N=1)	4.8 (N=13)	1.9 (N=5)	4.1 (N=11)	5.6 (N=15)	5.9 (N=16)
Intellectual Development	100 (N=269)	83.6 (N=225)	1.1 (N=3)	0.7 (N=2)	*	4.8 (N=13)	*	3.7 (N=10)	3.0 (N=8)	3.0 (N=8)
Social/ Emotional Development	100 (N=269)	84.0 (N=226)	5.9 (N=16)	*	0.4 (N=1)	3.7 (N=10)	*	1.9 (N=5)	2.6 (N=7)	1.5 (N=4)

school systems are very infrequently used for regular screening services (from 1.1% to 10.0%, depending on the screening area).

Funding Sources

Regardless of screening area, screening services were usually funded by Head Start Basic or Supplemental Grants for about 50 percent of the children, depending on the screening area (see Table 6.11). State or public school monies were a secondary source of funding for screening.[1] However, Head Start staff did not know or did not report the funding source for screening services for up to 33.1 percent of the sample children, depending on the screening area. It is therefore difficult to accurately describe funding sources with such a large "no response" category.[2]

Techniques Used for Screening

Table A6.3 - A6.14 (see Appendix A) outline the techniques used for regular and additional screening in each screening area. Since most children did not receive additional screening (between 74.0 and 87.7%), only the predominantly used techniques for regular screening of sample children will be summarized below:

- For vision, the Snellen Picture Chart and the Titmus were most frequently used (43.9 and 10.8%, respectively).
- An unspecified audiometric exam was the most frequently used technique for hearing screening (43.5%). This category encompasses a variety of techniques that are used in conjunction with audiometric equipment (e.g., pure tone sweep, air and/or bone conduction, etc.)
- In the area of physical coordination and development, a physical exam or the Denver Developmental Screening Test were most frequently used (29.0 and 13.4%, respectively).
- An unspecified formal (standardized) test was most frequently used for purposes of speech and language screening (24.2%) although the Peabody Picture Vocabulary Test, observation techniques, and locally designed assessments were

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[1] It is not known if State funds included Medicaid monies.

[2] Although the large "no response" category to the question concerning sources of funds for screening services makes conclusions tenuous, it is interesting to note that EPSDT was infrequently mentioned in this regard (see Table 6.11).

TABLE 6.11

Funding Sources for Regular Screening by Screening Area

Screening Area	Total** % of Row	Head Start Basic Grant % of Row	Head Start Supplemental (P.A. 26) % of Row	Joint Funding[1] (Head Start/ other agency) % of Row	Public Schools % of Row	State Funds % of Row	Other[2] % of Row	No Response % of Row
	Funding Source							
Vision	100 (N=269)	44.6 (N=120)	6.3 (N=17)	*	7.8 (N=21)	9.3 (N=25)	14.9 (N=40)	17.1 (N=46)
Hearing	100 (N=269)	31.2 (N=84)	17.5 (N=47)	0.4 (N=1)	8.6 (N=23)	12.3 (N=33)	15.6 (N=42)	14.5 (N=39)
Physical Coordination and Development	100 (N=269)	43.9 (N=118)	9.3 (N=25)	*	2.2 (N=6)	7.1 (N=19)	13.4 (N=36)	24.2 (N=65)
Speech and Language	100 (N=269)	24.5 (N=66)	24.2 (N=65)	1.5 (N=4)	7.8 (N=21)	8.6 (N=23)	8.9 (N=24)	24.5 (N=66)
Intellectual Development	100 (N=269)	47.6 (N=128)	7.4 (N=20)	1.1 (N=3)	2.2 (N=6)	4.8 (N=13)	6.3 (N=17)	30.5 (N=82)
Social/Emotional Development	100 (N=269)	42.0 (N=113)	12.3 (N=33)	0.7 (N=2)	2.6 (N=7)	3.7 (N=10)	5.6 (N=15)	33.1 (N=89)

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[1] Does not include Head Start/BEH Joint Funding

[2] Includes Head Start/BEH Joint Funding, EPSDT, and other Education for the Handicapped Act Funds

also used with some regularity (8.2, 11.9, and 8.2%, respectively).

- A diversity of techniques were used for screening in intellectual development, including the Denver Developmental Screening Test, the Learning Accomplishment Profile, other formal (standardized) tests, and locally designed assessments (14.1, 12.6, 11.5, and 14.5%, respectively).
- Again, no one technique was predominantly used for social/emotional development screening, although frequently used techniques include observation, the Denver Developmental Screening Test, locally designed assessments, and the Learning Accomplishment Profile (17.1, 13.0, 11.5, and 9.3%, respectively).

Identification of Potential Handicaps

Table 6.12 indicates the proportion of sample children for whom screening indicated a potential handicap in each screening area by primary handicapping condition. The areas enclosed in boxes indicate the relevant screening area(s) for each primary handicapping condition. For example, vision is the relevant screening area for children who were classified as visually impaired. *Most of the children who were classified into a given handicapping category were identified as potentially handicapped in the relevant screening area* (ranging from 71.0% to 93.3%, depending on the handicapping condition/screening area). The table also indicates that for children in any of the handicapping conditions, screening results often suggested potential handicaps in other secondary areas, as well.

Theoretically, within each handicapping condition, screening results should have indicated a potential handicap in the relevant area for 100 percent of the children classified as handicapped. In reality, potential handicaps in the relevant developmental areas were indicated for 71.0 to 93.3 percent of the children in a given handicap category. The other 7 to 30 percent of the children in a given handicapping condition were identified as handicapped without having been screened in the appropriate area or else their

TABLE 6.12

Areas Where Screening Indicated a Potential Handicap by Reported Primary Handicapping Condition

		Screening Areas					
Handicapping Condition	Total** % of Row	Vision % of Row	Hearing % of Row	Physical Coordination and Development % of Row	Intellectual Development % of Row	Speech and Language Development % of Row	Social/Emotional Development % of Row
Visually Impaired	(N=15)	93.3 (N=14)	6.7 (N=1)	20.0 (N=3)	20.0 (N=3)	13.3 (N=2)	20.0 (N=3)
Blind	(N=6)	83.3 (N=5)	16.7 (N=1)	33.3 (N=2)	16.7 (N=1)	33.3 (N=2)	33.3 (N=2)
Hearing Impaired	(N=21)	4.8 (N=1)	90.5 (N=19)	23.8 (N=5)	19.0 (N=4)	42.8 (N=9)	19.0 (N=4)
Deaf	(N=2)	*	*	*	*	100.0 (N=2)	*
Physically Handicapped	(N=37)	18.9 (N=7)	5.4 (N=2)	73.0 (N=27)	18.9 (N=7)	37.8 (N=14)	18.9 (N=7)
Speech Impaired	(N=59)	3.4 (N=2)	6.8 (N=4)	13.6 (N=8)	11.2 (N=7)	93.2 (N=55)	15.2 (N=9)
Health/Developmentally Impaired	(N=30)	10.0 (N=3)	16.8 (N=5)	80.0 (N=24)	30.0 (N=9)	40.0 (N=12)	30.0 (N=9)
Mentally Retarded	(N=35)	8.6 (N=3)	14.3 (N=5)	51.4 (N=18)	77.4 (N=24)	57.1 (N=20)	28.6 (N=10)
Learning Disabled	(N=31)	9.7 (N=3)	12.9 (N=4)	45.2 (N=14)	71.0 (N=22)	64.5 (N=20)	54.8 (N=17)
Emotionally Disturbed	(N=33)	9.1 (N=3)	18.2 (N=6)	15.2 (N=5)	30.3 (N=10)	33.3 (N=11)	90.9 (N=30)

Note: Each percentage was derived from the total number of cases within each handicap classification. Thus, the first cell shows that 14, or 93.3%, of the 15 cases in which visual impairment was reported as the primary handicapping condition, received screening in the vision diagnostic area. The screening areas of primary concern to each handicapping condition are enclosed in boxes.

screening results did not indicate a potential handicap in that area. However, this finding does not imply that this group of children received substandard screening services. Some children were diagnosed as handicapped prior to program entry and, in these cases, the program staff may have elected to omit screening in the diagnosed areas for these children - in which case, the children may still have been appropriately classified. Screening may also have been considered to have been an unnecessary step for children who are obviously, visibly handicapped and these children may have been directly referred for diagnostic services. For example, Head Start staff can immediately determine that a child with an artificial limb will have problems with physical coordination without waiting for screening results, and that child can be immediately referred for a functional assessment in that area.

Relationship Between Screening and Confirmation[1]

When screening indicates a potential handicap in a developmental area, children should be referred to appropriate specialists for more extensive evaluation. Frequently children may manifest potential handicaps in more than one developmental area,[2] and, if this is the case, they should be evaluated in each of the suspect areas. A child should only be identified as handicapped in a given area if his/her handicap is confirmed by a professional diagnostician.

Table 6.13 illustrates the frequency with which potential handicaps identified through screening were diagnosed as confirmed handicaps. *In almost 70 percent of all instances of identification of a potential handicap, children received a confirmation of a handicap*

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[1] These data include primary as well as secondary handicaps. Thus, each child may be represented in more than one developmental area.

[2] For example, hearing impaired children often have problems in the area of speech and language as well as hearing.

TABLE 6.13

Cases In Which Suspected Handicaps Were Confirmed		
Screening Area	Number of Cases in which Screening Indicated Potential Handicap	Percent of Screening Cases in which Handicap was confirmed
Vision	41	61.0 (N=25)
Hearing	47	61.7 (N=29)
Physical Coordination and Development	106	73.6 (N=78)
Intellectual Development	87	66.7 (N=58)
Speech and Language	146	82.2 (N=120)
Social/Emotional Development	91	56.1 (N=51)
Total	518[1]	69.7 (N=361)

[1] This figure exceeds the sample size (N=269 children) because some children had more than one suspected handicaps.

in the relevant developmental area. The highest proportion of confirmed handicaps was in the area of speech and language where 146 cases were identified as potentially handicapped through the screening process, and 120 (82.2%) of those were confirmed. Social/emotional development had the lowest correspondence; 91 children were identified as potentially handicapped in this area, but only 51 (56.1%) were confirmed as handicapped in social/emotional development.

Non-Head Start Program Screening Services

Type of Screening Services Provided

According to non-Head Start program staff report, 19 of the programs screen enrollees at the time of admission to the program (41.3%), and in an additional 14 programs (30%), enrollees are identified as handicapped prior to admission (see Table 6.14). It is not clear whether screening is a part of the identification procedures used in these 14 programs or not. As Table 6.15 indicates, non-Head Start programs that serve only handicapped children do not provide comprehensive screening to their enrollees upon program enrollment. *On the whole, then, non-Head Start programs seem to provide comprehensive screening services to their enrollees less frequently than do Head Start programs.* However, it is also clear that Head Start is a more comprehensive program than the group of non-Head Start programs studied, and it was expected that the non-Head Start programs would not provide screening services to the extent that Head Start does. Additionally, non-Head Start programs enroll children who are already diagnosed as handicapped to a greater extent than Head Start programs do, which reduces their need to conduct complete screening services.

TABLE 6.14

Screening Services Provided in Non-Head Start Programs	
Screening Service Type	% of Total
Enrollees screened at time of program admission	41.3 (N=19)
Enrollees identified as handicapped before entering program	30.4 (N=14)
Other	23.9 (N=11)
No Response	4.3 (N=2)
Total**	100 (N=46)

TABLE 6.15

Screening Services Provided by Non-Head Start Programs to Enrollees by Services to Non-Handicapped Children

		Screening Services		
Presence of Non-Handicapped Children	Total** % of Row	Enrollees Identified As Handicapped Prior to Program Entry % of Row	Enrollees Screened At Time of Program Admission % of Row	Other % of Row
Programs serving only handicapped children	(N=10)	40.0 (N=4)	*	60.0 (N=6)
Programs serving handicapped and non-handicapped children	100 (N=36)	41.7 (N=15)	38.9 (N=14)	19.5 (N=7)

Professional Providers Used for Screening Services

Across screening areas, non-Head Start programs primarily relied on psychologists/psychiatrists, speech therapists/audiologists, medical professionals, interdisciplinary teams and staff teachers for screening services (see Table 6.17). *As with Head Start programs, screening was most frequently conducted by a specialist trained in the appropriate area.* The most obvious difference between Head Start and non-Head Start programs is that non-Head Start programs primarily used psychologists/psychiatrists for intellectual development and social/emotional development screening, while Head Start handicapped children were primarily screened by program staff in these areas.

Agency Affiliation of Service Providers

The non-Head Start programs tended to use approximately the same pattern of agencies for screening services as did Head Start programs (see Table 6.18 and 6.7, respectively), except, of course, that Head Start programs relied more heavily on Head Start staff, while non-Head Start programs used the public school system more extensively. This is, in part, a function of the public school affiliation of some of the non-Head Start programs.

Techniques Used for Screening

Tables A6.15 - A6.20 (see Appendix A) present the techniques that non-Head Start programs reported they used for screening in each screening area. Approximately one-half of the programs did not report techniques used for each of the screening areas or did not conduct screening in the area, but the predominant types are summarized below. The techniques used are very similar to the ones used by Head Start, except that the non-Head Start programs infrequently reported

TABLE 6.16

Type of Screening Provided in Each Screening Area by non-Head Start Programs[1/]

	Screening Area					
Type of Screening	Vision % of Column	Hearing % of Column	Physical Development % of Column	Speech and Language % of Column	Intellectual Development % of Column	Social/Emotional Development % of Column
Total**	100 (N=30)	100 (N=30)	100 (N=30)	100 (N=30)	100 (N=30)	100 (N=30)
General (provided to all enrollees)	43.3 (N=13)	40.0 (N=12)	40.0 (N=12)	40.0 (N=12)	33.3 (N=10)	33.3 (N=10)
Specific (provided to selected enrollees	20.0 (N=6)	30.0 (N=9)	30.0 (N=9)	36.7 (N=11)	36.7 (N=11)	33.3 (N=10)
Do not screen in that area	36.7 (N=11)	30.0 (N=9)	30.0 (N=9)	23.3 (N=7)	30.0 (N=9)	33.3 (N=10)

[1/] Includes only programs that provided screening services (N=30).

TABLE 6.17

Type of Service Provider Who Performed Screening in Each Screening Area for Non-Head Start Programs

Screening Area	Providers									
	Not Reported	Psychologist/ Psychiatrist	Pediatrician/ Other Licensed Medical Professional	Speech Therapist/ Audiologist	Para-professional Medical Personnel	Social Worker	Public Health Nurse	Interdisciplinary Team	Staff Teacher	Other
Vision	31.2 (N=10)	*	28.1 (N=9)	*	3.1 (N=1)	*	21.9 (N=7)	9.4 (N=3)	6.2 (N=2)	25.0 (N=8)
Hearing	28.1 (N=9)	*	15.6 (N=5)	46.9 (N=15)	3.1 (N=1)	*	9.4 (N=3)	15.6 (N=5)	6.2 (N=2)	15.6 (N=5)
Physical Coordination and Development	28.1 (N=9)	*	40.6 (N=13)	*	6.2 (N=2)	6.2 (N=2)	9.4 (N=3)	18.8 (N=6)	6.2 (N=2)	31.2 (N=10)
Speech and Language	28.1 (N=9)	*	3.1 (N=1)	65.6 (N=21)	*	*	6.2 (N=2)	18.8 (N=6)	12.5 (N=4)	6.2 (N=2)
Intellectual Development	34.4 (N=11)	56.2 (N=18)	3.1 (N=1)	*	3.1 (N=1)	*	3.1 (N=1)	21.9 (N=7)	18.8 (N=6)	6.2 (N=2)
Social/ Emotional Development	31.2 (N=10)	31.2 (N=10)	3.1 (N=1)	3.1 (N=1)	3.1 (N=1)	3.1 (N=1)	3.1 (N=1)	28.1 (N=9)	25.0 (N=8)	12.5 (N=4)

Note: Only 32 Alternate programs provided screening services (including the programs that did not respond to the question related to type of screening services provided, Table 6.14). Percentages in each cell are computed on the basis of 32 rather than row or column totals because programs were allowed to indicate more than one type of provider for each screening area.

TABLE 6.18

Agencies That Provided Screening Services to Non-Head Start Programs by Screening Area

Screening Area	Agency Not Reported	Private Practitioner/ Consultant	Hospital	Public or State Health Department	Social Services Department	Public School System	Easter Seal Agency	University Affiliated Facilities	Other
Vision	31.2 (N=10)	21.9 (N=7)	3.1 (N=1)	12.5 (N=4)	3.1 (N=1)	25.0 (N=8)	3.1 (N=1)	9.4 (N=3)	12.5 (N=4)
Hearing	25.0 (N=8)	12.5 (N=4)	3.1 (N=1)	9.4 (N=3)	3.1 (N=1)	34.4 (N=11)	6.2 (N=2)	15.6 (N=5)	25.0 (N=8)
Physical Coordination and Development	25.0 (N=8)	37.5 (N=12)	*	6.2 (N=2)	3.1 (N=1)	21.9 (N=7)	15.6 (N=5)	6.2 (N=2)	34.4 (N=11)
Speech and Language	21.9 (N=7)	9.4 (N=3)	*	6.2 (N=2)	3.1 (N=1)	34.4 (N=11)	9.4 (N=3)	6.2 (N=2)	40.6 (N=13)
Intellectual Development	28.1 (N=9)	9.4 (N=3)	*	9.4 (N=3)	9.4 (N=3)	34.4 (N=11)	3.1 (N=1)	6.2 (N=2)	40.6 (N=13)
Social/ Emotional Development	28.1 (N=9)	9.4 (N=3)	*	12.5 (N=4)	6.2 (N=2)	34.4 (N=11)	3.1 (N=1)	9.4 (N=3)	40.6 (N=13)

Note: Only 32 Alternate programs provided screening services (including the programs that did not respond to the question related to type of screening services provided, Table 6.14). Percentages in each cell are computed on the basis of 32 rather than row or column totals because programs were allowed to indicate more than one type of provider for each screening area.

use of the Denver Developmental Screening Test or the Learning Accomplishment Profile, both of which were moderately used by Head Start in three screening areas.

- For vision, the Snellen Picture Chart was most frequently used (19.6%).
- An unspecified audiometric exam was most frequently used for hearing screening (23.9%). As with the Head Start programs, this category encompasses a diversity of techniques used in conjunction with audiometric equipment.
- A physical examination or a formal (standardized) test were most frequently used for physical coordination and development screening (17.4 and 10.9%, respectively).
- In the area of speech and language development, locally designed assessments, the Peabody Picture Vocabulary Test, or other formal (standardized) tests were most frequently used (15.2, 10.9, and 8.7%, respectively).
- Unspecified formal tests were most frequently used for screening in intellectual development.
- A diversity of techniques were used to screen in social/emotional development, including observation techniques, the Vineland Social Maturity Scale, and other formal (standardized) tests (13.0, 10.9, and 8.7%, respectively).

Summary of Findings

- About half of the sample handicapped children in Head Start received complete screening services (i.e., were screened in each of the six developmental areas), slightly less than half of the children were screened in fewer than the six developmental areas and no screening services were reported for a small proportion of the children. In terms of the individual developmental areas, almost all the children were screened for vision and hearing problems, and the screening areas most often omitted were intellectual development and social/emotional development.
- At least some screening services were conducted for 65 percent of the sample children within three months of program entry as recommended by the Performance Guidelines. Further, proportionately more children who received complete screening services were screened within three months of program entry as compared to children who received partial screening services. However, this also indicates that screening was not conducted within the time frame suggested by the Performance Guidelines in more than one-third of the cases.

- In most cases, the sample handicapped children's screening was most often conducted by a specialist trained in the appropriate area, except that Head Start staff (excluding specialists on the Head Start staff) most frequently conducted intellectual development and social/emotional development screening. Across all screening areas, the providers of screening services were most frequently employed by Head Start. Other predominant screening providers were affiliated with public or state health departments (vision and hearing screening), or were private practitioners (physical coordination and development and speech and language screening). The Head Start children were infrequently screened by professionals affiliated with the public school system. Finally, screening services were usually funded by Head Start Basic or Supplemental Grants.

- In a majority of the cases in which screening results indicated a potential handicap, children received a confirmation in the relevant developmental area. About 30 percent of the secondary suspected handicaps identified through screening were not confirmed in the diagnostic process.

- Less than half of the non-Head Start programs generally screen their enrollees at the time of admission. In about one-third of the programs, children are diagnosed as handicapped prior to program entry. These and other data indicate that non-Head Start programs enroll previously-diagnosed children to a greater extent than do Head Start programs and that Head Start programs provide screening and diagnostic services to previously nondiagnosed children more often than non-Head Start programs.

- Non-Head Start programs primarily used specialists in the appropriate developmental area to conduct screening services. The agency affiliations of the screening providers were similar to those of the Head Start providers, except that non-Head Start programs used the public school system extensively.

- Non-Head Start programs reported using the same pattern of screening techniques as did the Head Start programs, except that non-Head Start programs used the Denver Developmental Screening Test and the Learning Accomplishment Profile to a lesser extent that Head Start.

7

DIAGNOSTIC SERVICES

Upon completion of the screening process, those children identified as at "risk" are seen by appropriately trained professionals for further evaluation. The object of this second evaluation process occurs to identify handicapped children from those who are functioning within the range of normalcy or who are only temporarily impaired or delayed. This second, more comprehensive evaluation is termed diagnosis. A child may be considered to have an identified handicapping condition only if diagnostic results so indicate.

The basic issue addressed in this chapter is the extent to which the sample Head Start handicapped children received complete and appropriate diagnostic services. This includes a discussion of the following key questions:

- Did the handicapped children in the sample receive diagnostic services? How thorough were the reported diagnostic evaluations?
- Did the reported primary handicapping condition of each child correspond to the developmental areas(s) in which diagnosis was performed? Were any children identified as handicapped without an appropriate diagnostic evaluation?
- When in the program year were diagnostic evaluations completed? Did this allow sufficient time for planning classroom and home activities?
- Were properly trained professionals responsible for diagnoses and what agencies were primarily utilized?

- Did Head Start pay for diagnostic services or were other methods of payment arranged? To what extent were Head Start programs able to secure inkind services?
- What types of techniques were most frequently used to diagnose children?
- To what extent were parents involved in the diagnostic process? How were they involved?
- Were diagnostic files maintained on each child? What type of information was included in these files?
- What types of diagnostic services did non-Head Start programs provide?

For the purposes of this study, a model of the ideal diagnostic process was developed. This model was constructed, in part, from the guidelines set forth in the Head Start Performance Standards and, to a greater extent, from extensive conversations with the staff of the Administration for Children, Youth and Families. Therefore, some components of this model are mandated for all Head Start children while others are considered desirable, yet are not formally required.

The ideal diagnostic process may be viewed as consisting of three component functions: 1) confirmation; 2) functional assessment; and 3) development of service recommendations. A handicap can only be confirmed by a trained professional and confirmation may (but does not necessarily) entail the assignment of a categorical label, such as "visually impaired" or "emotionally disturbed." A functional assessment is a descriptive summary of what the child can and cannot do. While a confirmation indicates the nature of the handicap (visual, emotional), a functional assessment specifies the extent of the developmental disability (cannot focus on close objects, short attention span). Finally, recommendations are made for any necessary therapy, medication, specialized services or educational intervention. Diagnostic recommendations indicate the appropriate treatment to be provided.

Furthermore, the diagnostic process should not be an isolated occurrence, involving only the child and the diagnostician. Ideally, the child's parents and teacher should be involved in each step of the process. Their input into the preliminary gathering of information and their full understanding and awareness are needed to ensure that appropriate services are identified and utilized. Finally, all relevant diagnostic information should be translated into a comprehensive plan of services which is tailored to meet the individual needs of each child. This plan should encompass not only immediate treatment relating specifically to the handicapping condition(s) of each child, but also should include guidelines for educational instruction, parent involvement, social services, health and nutrition. A diagnostic file (whether part of the individual plan or as a separate entity) should be maintained for each handicapped child. This file should include written documentation of all information gathered through screening and diagnosis.

Information was gathered concerning these aspects of the diagnostic process as well as the time of completion of diagnosis, providers of diagnostic services, their agency affiliation, techniques, and funding. Six developmental areas which correspond to the areas in which screening is conducted were identified: vision, hearing, physical coordination and development, intellectual development, speech and language, and social/emotional development. Pertinent diagnostic information was recorded for each child according to the developmental area(s) in which diagnostic services were performed. In addition, comparisons with the 46 sample non-Head Start programs were addressed when appropriate. Within this chapter, all Head Start data are child-specific and all non-Head Start data are program-specific.

Head Start Diagnostic Services

Assignment of a Categorical Label

The categorizing of handicapped children has always been a sensitive issue because, in many cases, the assigned label will be applied to a child throughout his/her school career. Furthermore, in light of the recent accusations of cultural or racial biases inherent in many of the testing techniques, the appropriateness of the labels assigned often falls into serious question. This study did not attempt to determine if children who were identified as handicapped were categorized appropriately but rather if children were assigned a label on the basis of a diagnosis conducted by a qualified diagnostician. That is, no assessment of the quality of existing confirmation services was undertaken, but rather an examination of whether the children received the confirmation component of diagnostic services.

While most of the sample children received a confirmation of handicap in the developmental area appropriate to their reported primary handicapping condition, many did not. Table 7.1 shows the frequency of confirmations performed in the developmental area corresponding to the reported primary handicapping condition. The appropriate developmental area was determined on the basis of OCD Notice A-30-333-4, "Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start." Therefore, a child with a reported primary handicap of visual impairment or blindness should have received a confirmation of a handicap in the area of vision. Similarly, a deaf or hearing impaired child should have been confirmed as handicapped in the hearing developmental area.

A child reported to have a physical (orthopedic) handicap should show evidence of restricted development of gross or fine motor functions and; as such, should have a confirmed disability in the area of physical coordination and development. This same developmental area was considered appropriate for health or developmental impairments also, since the diagnostic criteria define these disabilities as "illnesses of a chronic nature or with prolonged convalescence including, but not limited to, epilepsy, hemophilia, severe asthma, etc.; all disorders which would be discovered, confirmed and affect a child's physical development."[1]

A speech impairment (communication disorder) includes "receptive and/or expressive language impairment, stuttering, chronic voice disorders, and serious articulation problems." While the diagnostic criteria point out that speech problems may be a result of other

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[1] It was explained to respondents that the developmental area of "physical coordination and development" included all health-related disorders.

TABLE 7.1

Frequency of Diagnostic Confirmations Made in the Appropriate Developmental Area by Reported Primary Handicapping Condition

Handicapping Condition and (Appropriate Developmental Area)[1]	Total % of Row	Confirmation Performed % of Row	No Reported Confirmation % of Row
Total	100.0 (N=269)	89.2 (N=240)	10.8 (N=29)
Visually Impaired (Vision)	100.0 (N=15)	93.3 (N=14)	6.7 (N=1)
Blind (Vision)	100.0 (N=6)	83.3 (N=5)	16.7 (N=1)
Hearing Impaired (Hearing)	100.0 (N=21)	95.2 (N=20)	4.8 (N=1)
Deaf (Hearing)	100.0 (N=2)	100.0 (N=2)	*
Physical Handicap (Physical Coordination and Development)	100.0 (N=37)	94.6 (N=35)	5.4 (N=2)
Health/Developmentally Impaired (Physical Coordination and Development)	100.0 (N=30)	80.0 (N=24)	20.0 (N=6)
Speech Impaired (Speech and Language)	100.0 (N=59)	98.3 (N=58)	2.0 (N=1)
Specific Learning Disability (Intellectual Development)	100.0 (N=31)	74.2 (N=23)	25.8 (N=8)
Serious Emotional Disturbance (Social/Emotional Development)	100.0 (N=33)	72.7 (N=24)	27.3 (N=9)
Mentally Retarded (Intellectually or Social/ Emotional Development)	100.0 (N=35)	[2]	

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[1] The appropriate developmental area was determined on the basis of OCD Notice A-30-333-4, "Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start."

[2] Twenty-seven mentally retarded cases received a confirmation of handicap in intellectual development; 11 mentally retarded children received a confirmation of handicap in social/emotional development. Some of the total 35 mentally retarded cases received a confirmation of handicap in both areas. Due to this overlap, it was considered that all mentally retarded children received a confirmation of handicap in an appropriate developmental area.

disorders such as hearing loss, mental retardation, emotional disturbance or health impairments, if speech impairment is the primary handicapping condition reported, a confirmation of a disability should have been reported in the area of speech and language. Children with secondary speech and language disorders should also receive a confirmation of handicap in this area, but the figures for this do not appear on Table 7.1.[1]

Children reported to be mentally retarded show "significant subaverage intellectual functioning accompanied by impairment in adaptive behavior." Since the diagnostic criteria for this handicapping condition apply to both intellectual and social/emotional development, these two areas were considered appropriate for a confirmation of mental retardation.

Children classified as seriously emotionally disturbed who received a confirmation of handicap in the area of social/emotional development were considered to have received appropriate diagnostic services, because this disability includes such behavioral symptoms as: "dangerously aggressive towards others, self-destructive, severely withdrawn," etc.

Finally, a child reported to have a specific learning disability was considered to have received appropriate diagnostic service if there was a confirmation of handicap in the area of intellectual development. Since a great deal of confusion seems to surround this particular handicap, the diagnostic criteria are cited in full:

> Children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such term does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of

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[1] Table A7.1 shows the confirmations of handicap (primary and secondary) performed in all developmental areas for children according to their reported primary handicapping condition (see Appendix A).

> mental retardation, of emotional disturbance, or of environmental disadvantage. *For preschool children precursor functions to understanding and using language spoken or written, and computational or reasoning ability are included.* (Professionals considered qualified to make this diagnosis are physicians and psychologists with evidence of special training in the diagnosis of learning disabilities and at least Master's degree level special educators with evidence of special training in the diagnosis of learning disabilities.)[1]

It is obvious that a learning disability is a complex condition, requiring specialized training in order to confirm such a handicap. Since the condition is a result of *psychological* malfunctions in the understanding or use of language, rather than the *production* of speech, per se, a confirmation of handicap in intellectual development (as opposed to speech and language) is necessary.

Returning to Table 7.1, it is obvious that for a sizeable number of children, there was no reported confirmation of handicap in the developmental area that corresponded to the child's reported primary handicapping condition. A total of 29 children (10.8% of the sample) had no reported confirmation of disability in the appropriate developmental area. Serious emotional disturbance was the handicapping condition with the greatest discrepancy; of the 33 cases reporting this as the *primary* handicapping condition, only 24 (72.7%) received a confirmation of handicap in social/emotional development. There were nine children to whom the label of emotionally disturbed was assigned without appropriate diagnostic confirmation. Specific learning disability was the handicapping condition with the next largest discrepancy; eight children of the 31 cases so labeled did not report a confirmation of handicap in the area of intellectual development.

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[1] OCD Notice A-30-333-4, "Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start," September, 1975, p. 3.

The learning disabled also received a large number of confirmations in other developmental areas which further indicates that there was some confusion surrounding the appropriate criteria for confirmation of this handicapping condition (see Appendix A, Table A7.1). In the order of descending frequency the figures are as follows: 24 of the 31 cases reported to be learning disabled (77.4%) received a confirmation of handicap in speech and language; 23 (74.2%) were confirmed as handicapped in intellectual development; 13 cases (41.0%) reported a confirmed disability in social/emotional development; 12 (38.7%) had a confirmed handicap in the area of physical coordination and development; four cases (12.9%) reported a confirmation of handicap in hearing; and two (6.5%) children also has confirmed disabilities in vision. *While these figures, in part, reflect children with multiple handicaps, the low proportion of the learning disabled with confirmed handicaps in intellectual development and the high frequency of confirmed disabilities in the areas of speech and language, social/emotional development, and physical coordination and development, indicate a general confusion and lack of knowledge concerning this handicapping condition.*

In contrast, deaf, speech impaired, and hearing impaired children had the highest frequency of appropriate diagnostic confirmation. Both of the deaf children in the study sample received a confirmation of handicap in hearing; 58 of the 59 children for whom speech impairment was the primary handicapping condition (98.3%) had a confirmed disability in speech and language; and 95.2% (20 of the 21 cases) of the hearing impaired children were confirmed as such in the area of hearing.

Despite the fact that no "hard data" were collected on the validity of the assigned handicap labels, even the ones that were assigned as a result of appropriate confirmation procedures, field staff had extensive opportunity to observe children identified as handicapped. The interviewers reported that examples of both abuse and proper use of categorical labels were evident in the sample Head Start programs. Some children had been labeled as handicapped due to a temporary ear infection (hearing impaired), an allergic reaction to a deodorizer (health or developmentally delayed) or an "unusual navel size" (physical handicap). One Head Start director expressed concern because of the large number of Black children diagnosed as "speech impaired" because of their rural dialect. In contrast, other programs were extremely cautious about the procedures and outcomes of assigned categorical labels. Translated tests and trained bilingual testers were required in one program with a predominantly Spanish-speaking population of children. In another instance, a child who was assumed at first to be a behavior problem was later discovered to be hearing impaired. As a result, the teacher altered her classroom approach to the child (seating him close to her, making sure he watched her as she gave instructions) and the behavior problems disappeared.

Finally, field staff encountered one case in which a child was referred to Head Start by the public schools because of a learning disability. Several weeks in the program convinced Head Start staff that there was nothing abnormal about the child and he was reevaluated by an independent diagnostic team. This subsequent evaluation revealed no evidence of a learning disability and the child's records were corrected accordingly.

Time of Completion of Diagnostic Services

After screening indicates a potential handicap, the prompt receipt of diagnostic services is of the utmost importance. Delays in professional diagnosis impede remediation and/or treatment and thus effectively withhold needed services for handicapped children. An individual plan of services cannot be properly drawn up if the existence, nature, and extent of a child's handicap are not known. Finally, conditions of a mild or temporary nature may develop into more severe or chronic problems if left undetected or untreated for a long period of time.

Table 7.2 shows the time of completion of diagnostic confirmations performed for Head Start children. Table 7.3 shows when the sample children, according to their reported primary handicapping condition, received a confirmation of a disability in the developmental area which corresponds to this primary handicap (the area of

TABLE 7.2

Dates of Confirmation of Handicap for Head Start Children		
Confirmation Date	Percent of Primary Handicaps	Percent of all[1/] Handicaps
August 1 - October 31, 1976	12.4 (N=36)	14.6 (N=69)
November 1, 1976 - January 31, 1977	21.6 (N=58)	29.3 (N=139)
February 1 - April 30, 1977	15.6 (N=42)	20.2 (N=96)
After April 30, 1977	1.5 (N=4)	1.3 (N=6)
Prior to August 1, 1976	33.5 (N=90)	34.0 (N=161)
No Confirmation	10.8 (N=29)	n/a
Date Unknown	3.7 (N=10)	0.6 (N=3)
TOTAL **	100 (N=269)	100 (N=474)

[1/] Includes both primary and secondary confirmed handicaps.

TABLE 7.3

Dates of Confirmation of Handicap in Area of Primary Concern by Handicapping Condition for Head Start Children

Confirmation Date	Diagnostic Area and Handicapping Condition					
	Vision Confirmation		Hearing Confirmation		Physical Confirmation	
	Visually Impaired % of Column	Blind % of Column	Hearing Impaired % of Column	Deaf % of Column	Physical Handicap % of Column	Health/Developmentally Impaired % of Column
Total**	100 (N=15)	100 (N=6)	100 (N=21)	100 (N=2)	100 (N=37)	100 (N=30)
August 1 - October 31, 1976	13.3 (N=2)	*	*	*	13.5 (N=5)	13.3 (N=4)
November 1, 1976 January 31, 1977	20.0 (N=3)	*	42.9 (N=9)	*	10.8 (N=4)	6.7 (N=2)
February 1 - April 30, 1977	13.3 (N=2)	16.7 (N=1)	9.5 (N=2)	50.0 (N=1)	2.7 (N=1)	16.7 (N=5)
After April 30, 1977	6.7 (N=1)	*	*	*	*	*
Prior to August 1, 1976	40.0 (N=6)	66.7 (N=4)	42.9 (N=9)	50.0 (N=1)	64.9 (N=24)	43.3 (N=13)
No Confirmation	6.7 (N=1)	16.7 (N=1)	4.8 (N=1)	*	5.4 (N=2)	20.0 (N=6)
Date Unknown	*	*	*	*	2.7 (N=1)	*

Confirmation Date	Diagnostic Area and Handicapping Condition				
	Speech Confirmation	Intellectual Confirmation		Social/Emotional Confirmation	
	Speech Impaired % of Column	Specific Learning Disability % of Column	Mentally Retarded % of Column	Mentally Retarded % of Column	Serious Emotional Disturbance % of Column
Total**	100 (N=59)	100 (N=31)	100 (N=35)	100 (N=35)	100 (N=33)
August 1 - October 31, 1976	25.4 (N=15)	16.1 (N=5)	2.9 (N=1)	*	12.1 (N=4)
November 1, 1976 - January 31, 1977	28.8 (N=17)	25.8 (N=8)	25.7 (N=9)	5.7 (N=2)	18.2 (N=6)
February 1 - April 30, 1977	25.4 (N=15)	9.7 (N=3)	8.6 (N=3)	2.9 (N=1)	27.3 (N=9)
After April 30, 1977	*	*	2.9 (N=1)	*	[illegible] (N=2)
Prior to August 1, 1976	16.9 (N=10)	22.6 (N=7)	37.1 (N=13)	20.0 (N=7)	9.1 (N=3)
No Confirmation	1.7 (N=1)	25.8 (N=8)	22.9 (N=8)	68.6 (N=24)	27.3 (N=9)
Date Unknown	1.7 (N=1)	*	*	2.9 (N=1)	*

vision for the blind and visually impaired, etc.). This will be referred to as the area of "primary concern" throughout the text and tables.

Prior to the beginning of the program year (August 1, 1976) 90 of the sample cases (33.5%) had already been confirmed as handicapped in the area of primary concern. This would include children who had been in Head Start the previous year and received diagnostic services at that time. Others were diagnosed at birth or soon after and either were recruited by Head Start as handicapped children or were routinely enrolled (with or without prior knowledge of the handicap). The manner in which Head Start programs dealt with information concerning previously diagnosed handicaps varied greatly. In some cases, the parent would simply tell the Head Start staff of the child's condition. The information would be accepted as true and the child categorized as the parent indicated. In other programs, however, a concentrated effort was made to contact the original diagnostician and to obtain copies of all information pertinent to the child. In one case, this involved tracing the diagnostician to another State some 1,000 miles away.

During the first quarter (August through October) of the 1976-77 program year, only 36 of the sample 269 children (12.4%) received a confirmation of handicap in the area of primary concern. The rate of completion rose in the second quarter (November through January), when 58 children (21.6%) received a diagnostic confirmation in the area of primary concern. *Thus, including the children whose handicaps were confirmed prior to program entry, 184 children (68.4%)[1] had received a confirmation of handicap in the area of primary concern by the end of January.* This corresponds to the fact that screening was completed for 65 percent of the children by the end of December (or within 90 days of program entry) and indicates that the screened children were subsequently referred to diagnosticians for confirmation services. However, within this time frame, these children did not receive diagnostic confirmations until almost half of the school year was over. This allows little time for appropriate planning and development of an individual plan of services. Furthermore, one-third of the children's handicaps were not confirmed by the time the program year was half over.

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[1] This includes the 90 cases diagnosed prior to the program year, 36 cases confirmed as handicapped in the area of primary concern during the first quarter of the program year, and 58 cases receiving diagnostic confirmation during the second quarter.

During the third quarter of the program year (February through April) 42 cases (15.6%) were confirmed as handicapped in the area of primary concern. After April 30th, four more children (1.5%) received a diagnostic confirmation. In several cases, a confirmation of handicap was not performed until shortly before the scheduled site visit for this study. *Clearly, diagnostic confirmations of a handicap frequently occurred too late in the program year for necessary planning and procurement of services.*

Those children classified as seriously emotionally disturbed did not receive as complete or prompt confirmation services as the children with other types of handicaps (see Table 7.3). Of the 33 cases reported to be primarily emotionally disturbed, nine children (27.3%) were not confirmed as handicapped in social/emotional development until the third quarter of the program year; two cases (6.1%) did not receive a diagnostic confirmation until after April 30th; and nine more cases (27.3%) had no reported confirmation in the area of primary concern.

The duplicated total column of Table 7.2 shows the number of diagnostic confirmations performed for the sample children in all developmental areas. This includes confirmations of handicap in the developmental area that corresponds to the child's reported primary handicapping condition as well as any confirmed handicaps of a secondary nature (such as the hearing impaired child who also has a confirmed impairment in speech and language). A total of 474 diagnostic confirmations were reported for the sample 269 children. Most of these confirmations were performed either prior to the program year (N=161) or between the months of November and January (N=139).

Professional Diagnostic Providers

It is important that any confirmation of handicap be performed by appropriate and qualified personnel. If lay people without specific training or professionals outside their area of specialization are performing diagnostic confirmations, then resulting misdiagnoses and/or inappropriate treatment may occur. The importance of using the proper professional for diagnostic services is underscored in the "Announcement of Diagnostic Criteria" (OCD Notice A-30-333-4), which indicates, in many instances, the appropriate professional who may confirm specific types of handicapping conditions. For example, "professionally qualified personnel" who may confirm a child as seriously emotionally disturbed are cited as psychologists or psychiatrists. A child may be diagnosed as learning disabled by physicians, psychologists, or master's degree level educators, all of whom must have special training in the diagnosis of learning disabilities.

The primary providers of diagnostic confirmations for the sample children[1] *(Table 7.4) were, in general, appropriate and qualified personnel.* Pediatricians and other licensed medical professionals provided the majority of vision (76.5%) and physical development (54.9%) handicap confirmations.[2] Speech therapists/audiologists did the major portion of the hearing (63.4%) and speech and language (74.1%) handicap confirmations.[3] In intellectual and social/emotional development, psychologists or psychiatrists were responsible for most handicap confirmations (55.2% and 71.2%, respectively).[4]

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[1] This discussion is based on child-specific data.

[2] These professionals performed 26 of the 34 confirmations of handicap in vision and 56 of the 102 in physical coordination and development.

[3] These professionals provided 26 of the 41 confirmations of handicap in hearing and 103 of the 139 in speech and language.

[4] Figures represent 48 of the 87 intellectual confirmations of handicap and 52 of the 74 in social/emotional development.

TABLE 7.4

Professional Providers Who Did Confirmation of Handicaps by Diagnostic Area

Diagnostic Area	Provider of Confirmation of Handicap							
	Total ** % of Row	Psychologist/ Psychiatrist % of Row	Pediatrician/ Other Licensed Medical Professional % of Row	Speech Therapist/ Audiologist % of Row	Paraprofessional Medical Personnel % of Row	Interdisciplinary Team % of Row	Head Start Staff Teacher % of Row	Other % of Row
Vision	100 (N=34)	2.9 (N=1)	76.5 (N=26)	*	*	*	*	20.6 (N=7)
Hearing	100 (N=41)	*	34.1 (N=14)	63.4 (N=26)	*	2.4 (N=1)	*	
Physical Coordination and Development	100 (N=102)	14.7 (N=15)	54.9 (N=56)	1.0 (N=1)	*	10.8 (N=11)	2.9 (N=3)	15.7 (N=16)
Intellectual Development	100 (N=87)	55.2 (N=48)	13.8 (N=12)	*	*	18.4 (N=16)	4.6 (N=4)	8.0 (N=7)
Speech and Language Development	100 (N=139)	6.5 (N=9)	3.6 (N=5)	74.1 (N=103)	0.7 (N=1)	6.5 (N=9)	1.4 (N=2)	7.2 (N=10)
Social/Emotional Development	100 (N=73)	71.2 (N=52)	11.0 (N=8)	1.4 (N=1)	1.4 (N=1)	9.6 (N=7)	2.7 (N=2)	2.7 (N=2)

In contrast to the frequent use of Head Start teachers for screening purposes (see Chapter 6, Table 6.7), especially in the areas of intellectual and social/emotional development, very few Head Start teachers provided diagnostic confirmations of handicap.[1] This undoubtedly reflects the high degree of training necessary to become a qualified diagnostician, whereas screening providers can be relatively easily and quickly trained. Teachers are often in the best position to objectively observe their pupils every day and thus are used frequently for screening purposes. *Therefore, Head Start teachers provided screening services with great frequency, but for the more specialized function of diagnostic confirmation, other professionals were used.*

Agency Affiliation of Diagnostic Providers

The agencies with which professionals providing confirmations of handicaps were affiliated indicates the degree to which Head Start sought out and coordinated with external resources in the provision of diagnostic services (see Table 7.5). Private practitioners/consultants and other, unspecified agencies[2] were the two most frequent responses. Of the total 476[3] confirmations of handicap, private practitioners/consultants provided 134 diagnostic confirmations

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[1] Of the 87 confirmations of handicap in intellectual development, only four were performed by Head Start teachers. However, 122 children were screened in the area of intellectual development by Head Start teachers. Similarly, in social/emotional development, Head Start teachers confirmed a handicap in only two cases, but they screened 110 children in this area.

[2] These would include private hospitals, public or private clinics and cases where the agency affiliation was unknown. This latter response occurred fairly frequently due to the number of children diagnosed at birth or soon after and cases where the diagnostician was known, but the agency affiliation was unclear or ambiguous.

[3] This figure includes confirmations of handicap in the area of primary concern as well as confirmed handicaps of secondary importance for the multiply disabled.

TABLE 7.5

Agencies Providing Confirmation of Handicap by Diagnostic Area

Diagnostic Area	Total** % of Row	Private Practitioner/ Consultant % of Row	Hospital (public) % of Row	Local or State Health/ Social Services Department % of Row	Public School System % of Row	Easter Seal/ Crippled Children Assoc./ Assoc. for Retarded Children % of Row	University Affiliated Facilities % of Row	Head Start % of Row	Other % of Row
Vision	100 (N=34)	47.1 (N=16)	8.8 (N=3)	8.8 (N=3)	*	2.9 (N=1)	14.7 (N=5)	*	17.6 (N=6)
Hearing	100 (N=41)	39.0 (N=16)	4.9 (N=2)	4.9 (N=2)	*	4.9 (N=2)	4.9 (N=2)	7.3 (N=3)	34.1 (N=14)
Physical Coordination and Development	100 (N=102)	25.5 (N=26)	14.7 (N=15)	7.8 (N=8)	3.9 (N=4)	9.8 (N=10)	9.8 (N=10)	4.9 (N=5)	23.5 (N=24)
Intellectual Development	100 (N=87)	24.1 (N=21)	2.3 (N=2)	4.6 (N=4)	12.6 (N=11)	2.3 (N=2)	12.6 (N=11)	9.2 (N=8)	32.2 (N=28)
Speech and Language	100 (N=139)	19.4 (N=27)	3.6 (N=5)	4.3 (N=6)	15.1 (N=21)	5.8 (N=8)	11.5 (N=16)	15.1 (N=21)	25.2 (N=35)
Social/Emotional Development	100 (N=73)	38.4 (N=28)	*	4.6 (N=3)	5.5 (N=4)	1.4 (N=1)	5.5 (N=4)	8.2 (N=6)	37.0 (N=27)

(28.2%) and other agencies also provided 134 handicap confirmations (28.2%). Combined, then, these agencies represent over half of the diagnostic confirmations performed (268 diagnostic confirmations or 56.3%). Sometimes the same diagnostician was used for several children, so that children with suspected handicaps would be routinely referred to these established professionals for diagnostic services. More frequently, however, each child was seen by a different professional and these diagnosticians were not necessarily used again for similar services for other children.

University Affiliated Facilities were used with the next greatest frequency; professionals associated with this type of organization provided 48 (10.1%) of the total number of confirmations. Programs located near universities often tapped the abundant resource of student apprentices, especially in the area of speech and languange and intellectual development. Diagnostic providers associated with universities provided 21 of the 139 confirmations of handicap in speech and language (15.1%) and eight of the 87 (9.2%) performed in the area of intellectual development. Such arrangements with local colleges and universities seem to be mutually beneficial: students have an opportunity to train under actual field conditions and Head Start children receive prompt, inexpensive and thorough diagnostic services.

Head Start staff were responsible for 43 or 9.0 percent of all confirmations, the majority of these in speech and language (N=21). The higher number of diagnostic confirmations provided by Head Start staff as compared to the number done by Head Start teachers,[1/] indicates that the Head Start programs had a number of non-teaching professionals on staff (speech therapists and psychologists were most

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[1/] Head Start teachers were responsible for 11 diagnostic confirmations (see Table 7.4). However, when looking at the figures for the providing agencies, Head Start, as an agency, was responsible for 43 handicap confirmations. Therefore, 32 confirmations of handicap (43 total - 11 performed by teachers) were provided by non-teaching Head Start professionals.

frequent) who provided diagnostic confirmations). Other agencies such as the public school system, special purpose organizations, health or social service departments provided infrequent diagnostic services to Head Start children.[1]

The reasons for using the various agencies/professionals were basically two: these providers offered the best service available or were part of an established diagnostic service (Table 7.6). In every developmental area these two responses were consistently the highest, with the figures ranging from 25.6 percent (in physical coordination) to 41.1 percent (in social emotional development). It is important to note that a great many of the respondents felt that their established diagnostic procedures were also the best services available, so these two responses should not be considered as mutually exclusive. These two categories combined account for nearly three-fourths of all responses across all developmental areas. The expense of the service had little to do with the utilization of a particular professional or agency. The maximum number of cases in which cost was a factor in the choice of diagnostic services was only seven out of 125 diagnostic evaluations (5.6%) in the area of physical coordination and development. Availability of services (that is, the diagnostician was used because he/she was the only available service in the area) did not seem to be a significantly frequent reason either, ranging from no reported cases in vision to 10 (6.3%) in speech and language. A more sizeable proportion of cases were diagnosed prior to enrollment and, therefore, Head Start had no choice in the agency or professional used. The single largest area in which pre-enrollment diagnosis occurred was physical coordination and development, where nearly one-fourth of the 125 confirmed handicaps (31 cases or 24.8%) were diagnosed before the child's Head Start enrollment.

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[1] Public schools were responsible for 40 (8.4%) of the total 476 confirmed handicaps; special purpose agencies such as Easter Seals, Crippled Children's Associations and the Association for Retarded Children provided a combined total of 24 (5.0%) diagnostic confirmations; and Health or Social Service Departments 26 (5.5%) of the total.

TABLE 7.6

Reason for Use of Agencies/Professionals for Diagnostic Services by Diagnostic Area

Diagnostic Area	Reasons						
	Total ** % of Row	Least Expensive Service Available % of Row	Best Service Available % of Row	Only Service Available % of Row	Part of Established Diagnostic Service with Which Program is Associated % of Row	No Choice in the Matter Child Was Diagnosed Prior to Entrollment % of Row	Other % of Row
Vision	100 (N=55)	3.6 (N=2)	29.1 (N=16)	*	34.5 (N=19)	16.4 (N=9)	16.4 (N=9)
Hearing	100 (N=61)	3.3 (N=2)	41.0 (N=25)	1.6 (N=1)	26.2 (N=16)	14.8 (N=9)	13.1 (N=8)
Physical Coordination and Development	100 (N=125)	5.6 (N=7)	27.2 (N=34)	0.8 (N=1)	25.6 (N=32)	24.8 (N=31)	16.0 (N=20)
Speech and Language	100 (N=158)	3.2 (N=5)	38.6 (N=61)	6.3 (N=10)	39.2 (N=62)	8.9 (N=14)	3.8 (N=6)
Intellectual Development	100 (N=114)	5.3 (N=6)	36.0 (N=41)	6.1 (N=7)	37.7 (N=43)	10.5 (N=12)	4.4 (N=5)
Social/ Emotional Development	100 (N=107)	4.7 (N=5)	31.8 (N=34)	5.6 (N=6)	41.1 (N=44)	9.3 (N=10)	7.5 (N=8)

Funding Sources

Perhaps the single most difficult aspect of the diagnostic process to determine was who paid for the services. Many respondents simply did not know where the money came from or, in fact, if services were reimbursed. Table 7.7, which shows the types of funding sources used to provide confirmations of handicap in each of the developmental areas, must be interpreted keeping in mind these difficulties.

Head Start funds (Basic Grant and Program Account 26) were the predominant source of funding used to pay for diagnostic confirmations. Utilization of Program Account 26 funds ranged from 16.7 percent of the confirmations of handicap in physical coordination and development to 39.6 percent of the confirmations of handicap in speech and language. In addition, Head Start Basic Grant monies were used from 8.8 percent of the diagnostic confirmations in physical development to 28.8 percent of the confirmations of handicap in social/emotional development. Combined, Program Account 26 and Basic Grant funding provided well over half of the confirmations of handicap in intellectual, speech, and social/emotional development.

While the Head Start Program Performance Standards indicate that Head Start monies may be used to provide diagnostic services, the Standards also make it clear that this funding should be used only as a last resort: "Head Start funds may be used only when no other source of funding is available."[1/] While Head Start does not seem to make use of alternate sources of funding, inkind services seem to be virtually untapped. Inkind service delivery ranged from only 0.7 percent (1 of the 139 speech and language diagnostic confirmations) to 7.3 percent (3 of the 41 confirmations of handicap in hearing). Head Start programs were apparently able to locate only a small number of professionals who would perform diagnostic confirmations for free or less than the market value of their service.

[1/] Head Start Program Performance Standards, OCD Notice N-30-364-4, DHEW, July 1975, p. 27.

TABLE 7.7

Distribution of Funding Sources Used to Obtain Confirmation of Handicap by Diagnostic Area

Diagnostic Area	Source of Funding							
	Total** % of Row	Head Start Basic Grant % of Row	Head Start Supplemental (P.A.26) % of Row	Inkind Services % of Row	Joint Funding (Head Start/ Other agency) % of Row	Public Schools (Reimbursement of Services) % of Row	State Funds % of Row	Other[1] % of Row
Vision	100 (N=34)	14.7 (N=5)	17.6 (N=6)	*	*	2.9 (N=1)	29.4 (N=10)	35.3 (N=12)
Hearing	100 (N=41)	12.2 (N=5)	29.3 (N=12)	7.3 (N=3)	*	*	17.1 (N=7)	34.1 (N=14)
Physical Coordination and Development	100 (N=102)	8.8 (N=9)	16.7 (N=17)	2.9 (N=3)	2.9 (N=3)	3.9 (N=4)	27.5 (N=28)	37.3 (N=38)
Intellectual Development	100 (N=87)	18.4 (N=16)	35.6 (N=31)	2.3 (N=2)	2.3 (N=2)	5.9 (N=6)	20.7 (N=18)	13.8 (N=12)
Speech and Language	100 (N=139)	10.8 (N=15)	39.6 (N=55)	0.7 (N=1)	2.2 (N=3)	7.2 (N=10)	15.1 (N=21)	24.5 (N=34)
Social/Emotional Development	100 (N=73)	28.8 (N=21)	31.5 (N=23)	6.8 (N=5)	2.7 (N=2)	5.5 (N=4)	11.0 (N=8)	13.7 (N=10)

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[1] Includes EPSDT, Head Start/BEH Joint Funding, and other Education for the Handicapped Act Funds

Confirmations of handicap in the remaining developmental areas (vision, hearing and physical coordination) were funded predominantly by a combination of other funding sources such as EPSDT, joint funding arrangements with BEH, etc.[1] Included in this category would also be those occasions when parents paid for diagnostic services or when the funding source was unknown (this occurred primarily when children were diagnosed prior to Head Start enrollment).

Diagnostic Techniques

Tables A7.2-A7.7 (see Appendix A) show the types of techniques most frequently used during the diagnostic process. *In all cases except social/emotional development, objective, standardized instruments were primarily used to confirm a handicap.* Thus for vision, hearing, and physical development, routine opthomological, audiometric or physical exams were administered in the majority of cases (35.3%, 53.7% and 46.6%, respectively). In intellectual development, the Stanford Binet and other standardized tests combined to account for over 65 percent of the techniques used in that area. Similarly, standardized testing comprised nearly three-fourths of the speech and language diagnostic techniques (73.6%).[2] In social/emotional development, however, standardized tests accounted for only 34.7 percent of the techniques used; observational confirmations, on the other hand, were reported in 28 (38.9%) of the cases.

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[1] Vision: 12 of 34 confirmations of handicap or 35.3 percent; hearing: 14 of 41 confirmations of handicap or 34.1 percent; physical coordination and development: 38 of 102 confirmations of handicap or 37.3 percent.

[2] The Peabody Picture Vocabulary Test, Goldman Pristoe Test of Articulation, Carrow Test for Auditory Comprehension of Language, and other unspecified standardized tests were the most frequent standardized techniques used.

In all developmental areas, the Head Start staff did not know the type of technique utilized for diagnostic confirmations a substantial portion of the time, probably because the staff was not frequently involved in the confirmation process. This occurred most frequently in the area of vision (50.0%) and least in speech and language (17.1%).

Involvement of Parents in the Diagnostic Process

An important part of meeting the needs of handicapped children and a basic foundation of the Head Start philosophy is the involvement of parents in the health and welfare of their children. Without appropriate explanation and understanding of the special needs of their children, parents are not in a position to contribute toward (and may even impede) the development of their child. An examination of Table 7.8 shows the extent to which Head Start ensures parental understanding and involvement in the diagnostic process. *In only six cases (2.2%) were diagnostic results not generally shared with parents.*[1] For the remaining children, however, parents were informed of these results--in over half of the cases, by both the diagnostician and Head Start staff.[2] The favored method used to present diagnostic results to parents was a combination of written and verbal reports (93 or 65.5%). In addition to the presentation and explanation of diagnostic results, parents of over half the sample children (65.8%) were included as part of a diagnostic team (see Appendix A, Table A7.8).

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[1] From these data, it cannot be determined the extent to which parents understood the diagnostic results or even if they fully understood that their child had been determined to be handicapped. During the early stages of data collection for Phase II of this study, field staff discovered that some parents did not know, prior to the interview, that their child was considered handicapped. This issue will be explored in greater depth in the Phase II final report.

[2] Of the total 269 sample cases, both Head Start staff and the diagnostician explained diagnostic results to parents of 142 children (52.8%). In 77 cases (28.6%) the diagnostician alone was responsible for explaining results and in 30 cases (14.5%), Head Start staff explained the diagnostic results to parents.

TABLE 7.8

Manner in Which Diagnostic Results Were Explained to Head Start Children's Parents		
Way Explained	**% within Group**	**% of Total by Group**
Not Generally Explained	100.0 (N=6)	2.2 (N=6)
Explained by diagnostician:		28.6 (N=77)
method not specified	*	
written report	24.7 (N=19)	
verbal report	48.1 (N=37)	
written and verbal report	27.3 (N=21)	
Explained by Head Start staff:		14.5 (N=39)
method not specified	2.6 (N=1)	
written report	15.4 (N=6)	
verbal report	59.0 (N=23)	
written and verbal report	23.1 (N=9)	
Explained by staff/ diagnostician together:		52.8 (N=142)
method not specified	0.7 (N=1)	
written report	10.6 (N=15)	
verbal report	23.2 (N=33)	
written and verbal report	65.5 (N=93)	
Not reported	100.0 (N=5)	1.9 (N=5)
Total**	N=269	100 (N=269)

Development of a Diagnostic File

The maintenance of all records pertaining to the diagnostic services a child receives is of the utmost importance. Written reports of diagnostic evaluations, recommendations for service delivery and records of the services actually received are necessary to ensure that proper treatment is being provided. Furthermore, these records should aid in the development of an individual plan of services, especially in planning educational services and providing for health and nutrition needs.

Program records were located by field staff for 268 of the sample children; of these 268 children, 251 children (93.7%) had a diagnostic file. For the remaining 17 cases (6.7%), no written documentation of any diagnostic services was found. The quality and usefulness of these files varied greatly. For some children, copies of all test results, lengthy assessments and recommendations, and detailed procedures for referral and monitoring of special services were included in the diagnostic file. In other cases, however, the diagnostic file consisted of several scraps of paper containing prescriptions or appointments and little else that would be of help in planning or procuring services. In several instances, the diagnostic file did not support the assignment of handicapped labels.

The Functional Assessment Component of the Diagnostic Process[1]

In the ideal diagnostic process, a functional assessment (statement of what the child can and cannot do) is an integral part of the diagnostic evaluation of each child with a suspected handicap. In the best circumstances, the same professional who provided the confirmation of handicap would also have performed a functional assessment and provided recommendations. Furthermore, to be of use to the teacher and family, a functional assessment must be easily translated into guidelines for classroom and home activities.

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[1] Only major differences between the functional assessment and the confirmation components of the diagnostic model will be highlighted. Patterns of completion dates, providers, agencies, funding or techniques, etc. were similar for these components of the diagnostic process.

When the total number of reported functional assessments was broken down by those performed only in the developmental area corresponding to the child's primary handicapping condition (see Table 7.9), it is obvious that functional assessments fall somewhat behind confirmations of handicap in number. *Only 221 of the sample 269 cases (82.2%) received a functional assessment, but 240 children (89.2%) had a confirmation of handicap in the area of primary concern.*

While the learning disabled and emotionally disturbed children had a low frequency of functional assessments, which in turn corresponds to the relatively low incidence of confirmation of handicap for these two groups,[1/] health or developmentally impaired children received the lowest number of functional assessments (18 of 30 cases, or 60%). This may reflect the feeling that for this handicapping condition no assessment was needed because the extent of the child's functioning capabilities was self-evident or because the impairment was so mild that it did not limit the child's functioning at all. For example, one child reported to be health or developmentally impaired due to an anemic condition was in no way affected, either mentally, physically or emotionally by this condition. In fact, the only provision made for the child's condition was to watch the child's diet more carefully than for the other children.

The major areas in which functional assessments show divergent configurations from confirmations of handicap were in the types of professionals and agencies providing these services. Whereas Head Start provided only 9 percent of the diagnostic confirmations, 20 percent of the functional assessments were provided by Head Start (see Table 7.10). *This increase in Head Start's participation in this stage of the diagnostic process indicated that fewer functional assessments were provided by professional diagnosticians.*

[1/] Only 74.2 percent of the learning disabled (N=23) and 72.7 percent of the emotionally disturbed (N=24) received a functional assessment in the area of primary concern. These figures are identical to those for the confirmation component of the diagnostic process for these two groups.

TABLE 7.9

Frequency of Functional Assessments Made in the Appropriate Developmental Area by Reported Primary Handicapping Condition

Handicapping Condition and (Appropriate Developmental Area)[1]	Total % of Row	Functional Assessment Performed % of Row	No Reported Functional Assessment % of Row
Total (Across all Areas)	100.0 (N=269)	82.2 (N=221)	17.8 (N=48)
Visually Impaired (Vision)	100.0 (N=15)	60.0 (N=9)	40.0 (N=6)
Blind (Vision)	100.0 (N=6)	66.7 (N=4)	33.3 (N=2)
Hearing Impaired (Hearing)	100.0 (N=21)	81.0 (N=17)	19.0 (N=4)
Deaf (Hearing)	100.0 (N=2)	100.0 (N=2)	*
Physical Handicap (Physical Coordination/Development)	100.0 (N=37)	94.6 (N=35)	5.4 (N=2)
Health/Developmentally Impaired (Physical Coordination/Development)	100.0 (N=30)	60.0 (N=18)	40.0 (N=12)
Speech Impaired (Speech and Language)	100.0 (N=59)	91.5 (N=54)	8.5 (N=5)
Specific Learning Disability (Intellectual Development)	100.0 (N=31)	74.2 (N=23)	25.8 (N=8)
Serious Emotional Disturbance (Social/Emotional Development)	100.0 (N=33)	72.7 (N=24)	27.3 (N=9)
Mentally Retarded (Intellectual or Social/ Emotional Development)	100.0 (N=35)	[2]	[3]

[1] The appropriate developmental area was determined on the basis of OCD Notice A-30-333-4, "Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start."

[2] Twenty-five mentally retarded cases received a functional assessment in intellectual development; 13 mentally retarded children received an assessment in social/emotional development. Some of the 35 mentally retarded children received assessments in both areas. Due to this overlap, it is assumed that all mentally retarded cases received an assessment in an appropriate developmental area.

[3] It is assumed that N=0.

TABLE 7.10

Agencies that Provide Functional Assessment by Diagnostic Area

Diagnostic Area	Agency								
	Total** % of Row	Private Consultant/ Practitioner % of Row	Hospital (public) % of Row	Local or State Health/ Social Services Department % of Row	Public School System % of Row	Easter Seal/ Crippled Children Assoc./ Assoc. for Retarded Children % of Row	University Affiliated Facilities % of Row	Head Start % of Row	Other % of Row
Vision	100 (N=35)	40.0 (N=14)	5.7 (N=2)	8.6 (N=3)	*	2.9 (N=1)	2.9 (N=1)	25.7 (N=9)	14.3 (N=5)
Hearing	100 (N=41)	19.5 (N=8)	4.9 (N=2)	2.4 (N=1)	7.3 (N=3)	4.9 (N=2)	7.3 (N=3)	24.4 (N=10)	29.3 (N=12)
Physical Coordination and Development	100 (N=103)	20.4 (N=21)	12.6 (N=13)	7.8 (N=8)	5.8 (N=6)	8.7 (N=9)	7.8 (N=8)	16.5 (N=17)	20.4 (N=21)
Incellectual Development	100 (N=97)	20.6 (N=20)	2.1 (N=2)	4.1 (N=4)	11.3 (N=11)	2.1 (N=2)	10.3 (N=10)	22.7 (N=22)	26.8 (N=26)
Speech and Language	100 (N=147)	23.1 (N=34)	3.4 (N=5)	3.4 (N=5)	14.3 (N=21)	5.4 (N=8)	8.8 (N=13)	16.4 (N=24)	25.2 (N=37)
Social/Emotional Development	100 (N=91)	34.1 (N=31)	*	4.4 (N=4)	5.5 (N=5)	1.1 (N=1)	4.4 (N=4)	23.1 (N=21)	27.5 (N=25)

Head Start teachers provided proportionately more functional assessments than confirmations of handicap for the sample children (see Table 7.11). The proportion of teacher-conducted functional assessments ranged from 2.9 percent of the vision assessments to 15.4 percent of the assessments in social/emotional development. The remaining assessments performed by professionals affiliated with Head Start, but not by a Head Start teacher, were most often provided by speech therapists, psychologists or nurses on staff in the Head Start programs.[1]

The funding sources used to obtain functional assessments reflect the increased utilization of Head Start personnel (see Table 7.12). Use of Head Start Basic Grant monies to obtain functional assessments ranged from 11.6 percent of the speech and language assessments to 42.9 percent of the vision assessments. Head Start supplemental funds (Program Account 26) were used to pay for functional assessments from 17.1 percent (vision assessments) to 41.5 percent (speech and language assessments) of the cases. *Combined, Head Start funds paid for more than half of all functional assessments.* In contrast, while Head Start funding was used to obtain a large number of functional assessments, Head Start did not pay for the majority of all diagnostic confirmations (see Table 7.7).

The patterns of providers, agencies and funding sources, combined with the lower frequency of functional assessments vis-a-vis confirmations of handicap, all strongly indicate that the same professionals were not providing both a confirmation of handicap and an assessment. Head Start staff were the major providers of assessments.[2]

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[1] These professionals were responsible for approximately 55 of the functional assessments. This figure was derived by subtracting the number of cases in which teachers were the providers (N=48) from the number of cases in which Head Start was the providing agency (N=103).

[2] The qualifications of the Head Start staff to perform functional assessments cannot be determined on the basis of the data. However, a teacher who has been trained in the administration of a prescriptive diagnostic instrument, such as the Learning Accomplishment Profile, is qualified to perform such a functional assessment. Therefore, one cannot assume that Head Start staff are unqualified to conduct functional assessments.

TABLE 7.11

Professionals Who Provided Functional Assessment by Diagnostic Area

Diagnostic Area	Provider of Functional Assessment							
	Total** % of Row	Psychologist/ Psychiatrist % of Row	Pediatrician/ Other Licensed Medical Professional % of Row	Speech Therapist/ Audiologist % of Row	Paraprofessional Medical Personnel % of Row	Interdisciplinary Team % of Row	Head Start Staff Teacher % of Row	Other % of Row
Vision	100 (N=35)	2.9 (N=1)	68.6 (N=24)	*	8.6 (N=3)	*	2.9 (N=1)	17.1 (N=6)
Hearing	100 (N=41)	*	31.7 (N=13)	63.4 (N=26)	*	4.9 (N=2)	*	*
Physical Coordination and Development	100 (N=102)	10.8 (N=11)	42.2 (N=43)	*	*	14.7 (N=15)	12.7 (N=13)	19.6 (N=20)
Intellectual Development	100 (N=97)	48.5 (N=47)	5.2 (N=5)	*	*	23.7 (N=23)	12.4 (N=12)	10.3 (N=10)
Speech and Language Development	100 (N=147)	7.5 (N=11)	2.7 (N=4)	69.4 (N=102)	0.7 (N=1)	6.1 (N=9)	5.4 (N=8)	8.2 (N=12)
Social/Emotional Development	100 (N=91)	59.3 (N=54)	3.3 (N=3)	1.1 (N=1)	1.1 (N=1)	14.3 (N=13)	15.4 (N=14)	5.5 (N=5)

TABLE 7.12

Funding Sources Used to Obtain Functional Assessments by Diagnostic Area

Diagnostic Area	Source of Funding							
	Total** % of Row	Head Start Basic Grant % of Row	Head Start Supple- mental (P.A. 26) % of Row	Service Provided In kind % of Row	Joint Funding (Head Start/ other agency) % of Row	Public Schools (Reimbursement of Services) % of Row	State Funds % of Row	Other 1/ % of Row
Vision	100 (N=35)	42.9 (N=15)	17.1 (N=6)	*	*	2.9 (N=1)	14.3 (N=5)	22.9 (N=8)
Hearing	100 (N=41)	24.4 (N=10)	22.0 (N=9)	2.4 (N=1)	*	*	22.0 (N=9)	29.3 (N=12)
Physical Coordination and Development	100 (N=103)	19.4 (N=20)	19.4 (N=20)	3.9 (N=4)	1.0 (N=1)	4.9 (N=5)	23.3 (N=24)	28.3 (N=29)
Intellectual Development	100 (N=97)	22.7 (N=22)	40.2 (N=39)	2.1 (N=2)	1.0 (N=1)	6.2 (N=6)	15.5 (N=15)	12.4 (N=12)
Speech and Language	100 (N=147)	11.6 (N=17)	41.5 (N=61)	1.4 (N=2)	1.4 (N=2)	7.5 (N=11)	12.9 (N=19)	23.8 (N=35)
Social/ Emotional Development	100 (N=91)	31.9 (N=29)	37.4 (N=34)	4.4 (N=4)	1.1 (N=1)	5.5 (N=5)	7.7 (N=7)	12.1 (N=11)

[1/] Includes EPSDT, Head Start/BEH Joint Funding, and other Education for the Handicapped Act Funds

The Recommendation Component of the Diagnostic Process

The final step in the ideal diagnostic process entails the development of recommendations concerning treatment, therapy, educational instruction or any other special services. This last component is of vital importance for, as the Performance Standards state: "Examinations which do not lead to needed remedial or rehabilitative treatment represents [sic] a waste of time and money."[1/]

Table 7.13 shows that 46 of the sample children (17.1%) had no reported recommendations in the developmental area corresponding to the primary handicapping condition. Children classified as emotionally disturbed most frequently were without recommendations; 11 of 33 so categorized (33.3%) had no reported recommendations in the developmental area of primary concern.[2/]

As in the case with functional assessments, the quality and usefulness of diagnostic recommendations varied greatly. In some cases, an appointment for a later check-up or an eyeglass prescription was considered as a recommendation. In others, specific types of therapy, health considerations, suggestions for classroom activities or referrals to more specialized professionals/agencies for treatment were included.

The pattern of recommendation providers was similar to that for provision of confirmation of handicap. Head Start staff made recommendations in cases in which they did not perform confirmations, but this occurred infrequently. For example, Table 7.14 shows that 13.2 percent of the reported recommendations (62 of the 469 total recommendations) were provided by Head Start. Confirmations of handicap provided by Head Start only comprised 9.0 percent of the reported diagnostic confirmations (43 of the 476 total confirmations).[3/]

[1/] Head Start Program Performance Standards, OCD Notice N-30-364-4, DHEW, July 1975, p. 26.

[2/] Emotionally disturbed children also had the highest proportion of cases without reported diagnostic confirmations in the area of primary concern: 9 cases or 27.3 percent.

[3/] See Table 7.4.

TABLE 7.13

Frequency of Recommendations Made in the Appropriate Developmental Area by Reported Primary Handicapping Condition

Handicapping Condition and (Appropriate Developmental Area)[1]	Total % of Row	Recommendations Made % of Row	No Reported Recommendations % of Row
Total (Across all Areas)	100.0 (N=269)	82.9 (N=223)	17.1 (N=46)
Visually Impaired (vision)	100.0 (N=15)	73.3 (N=11)	26.7 (N=4)
Blind (vision)	100.0 (N=6)	83.3 (N=5)	16.6 (N=1)
Hearing Impaired (Hearing)	100.0 (N=21)	81.0 (N=17)	19.0 (N=4)
Deaf (Hearing)	100.0 (N=2)	100.0 (N=2)	*
Physical Handicap (Physical Coordination/Development)	100.0 (N=37)	83.8 (N=31)	16.2 (N=6)
Health/Developmentally Impaired (Physical Coordinator/Development)	100.0 (N=30)	73.3 (N=22)	26.7 (N=8)
Speech Impaired (Speech and Language)	100.0 (N=59)	93.2 (N=55)	6.8 (N=4)
Specific Learning Disability (Intellectual Development)	100.0 (N=31)	74.2 (N=23)	25.8 (N=8)
Serious Emotional Disturbance (Social/Emotional Development)	100.0 (N=33)	66.7 (N=22)	33.3 (N=11)
Mentally Retarded (Intellectually or Social/ Emotional Development)	100.0 (N=35)	[2]	[3]

[1] The appropriate developmental area was determined on the basis of OCD Notice A-30-333-4, "Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start."

[2] Twenty-six mentally retarded cases received recommendations in intellectual development; 13 mentally retarded children received recommendations in social/ emotional development. Some of the total 35 mentally retarded children received recommendations in both areas. Due to this overlap, it is assumed that all mentally retarded cases received recommendations in an appropriate developmental area.

[3] It is assumed that N=0.

TABLE 7.14

Distribution of Agencies Providing Recommendations by Diagnostic Area

Diagnostic Area	Agency								
	Total** % of Row	Private Consultant/ Practitioner % of Row	Hospital (public) % of Row	Local or State Health/ Social Services Department % of Row	Public School System % of Row	Easter Seal/ Crippled Children Assoc./ Assoc. for Retarded Children % of Row	University Affiliated Facilities % of Row	Head Start % of Row	Other % of Row
Vision	100 (N=30)	40.0 (N=12)	6.7 (N=2)	10.0 (N=3)	6.7 (N=2)	3.3 (N=1)	13.3 (N=4)	*	20.0 (N=6)
Hearing	100 (N=34)	35.3 (N=12)	5.9 (N=2)	5.9 (N=2)	2.9 (N=1)	5.9 (N=2)	8.8 (N=3)	8.8 (N=3)	26.5 (N=9)
Physical Coordination and Development	100 (N=98)	21.4 (N=21)	14.3 (N=14)	8.2 (N=8)	6.1 (N=6)	7.1 (N=7)	10.2 (N=10)	11.2 (N=11)	21.4 (N=21)
Intellectual Development	100 (N=91)	24.2 (N=22)	1.1 (N=1)	4.4 (N=4)	11.0 (N=10)	2.2 (N=2)	13.2 (N=12)	14.3 (N=13)	29.7 (N=27)
Speech and Language	100 (N=137)	19.7 (N=27)	3.6 (N=5)	3.6 (N=5)	15.3 (N=21)	5.1 (N=7)	10.2 (N=14)	17.5 (N=24)	24.8 (N=34)
Social/Emotional Development	100 (N=79)	34.2 (N=27)	*	5.1 (N=4)	6.3 (N=5)	*	7.6 (N=6)	13.9 (N=11)	32.9 (N=26)

Completeness of the Diagnostic Process

Table 7.15 illustrates the relative frequency of completion of each of the previously discussed diagnostic components. *Broken down by reported primary handicapping condition and appropriate developmental area for diagnosis, it is clear that the emotionally disturbed and learning disabled have the lowest incidence of complete diagnostic services.* The average rate of completion for all sample children is as follows: 89.2 percent of confirmation of handicap (N=240); 82.2 percent for functional assessments (N=221); and 82.9 percent for recommendations (N=223). However, for emotionally disturbed children diagnostic confirmations were reported for only 72.7 percent of the 33 cases so classified (N=24); 72.7 percent reported functional assessments (N=24); and, 66.7 percent reported recommendations (N=22). Similarly, only 23 of the 31 children reported to be learning disabled (72.7%) received complete diagnostic services.

Of the 30 children classified as health or developmentally impaired, 24 (80.0%) received a confirmation of handicap in the appropriate developmental area. This figure drops to 18 (60.0%) when looking at functional assessments and then increases to 22 (73.3%) cases reporting recommendations.

In summary, the diagnostic components specifically required by the Transmittal Notice 75.11 (confirmation of handicap and recommendations) are the components of the diagnostic process that are completed most frequently. While functional assessments are not required, these were reported almost as often as recommendations. However, children with certain handicapping conditions receive much less thorough diagnostic services than the average for the total sample. Specifically, emotionally disturbed, learning disabled, and health/developmentally impaired children were less likely to receive the full range of diagnostic services than children with other disabilities.

TABLE 7.15

Frequency of Completion of Diagnostic Components by Reported Primary Handicapping Condition and Appropriate Developmental Area

Handicapping Condition and (Appropriate Developmental Area)[1]	Total % of Row	Confirmation Performed % of Row	Functional Assessment Performed % of Row	Recommendations Made % of Row
Total (Across all Areas)	100.0 (N=269)	89.2 (N=240)	82.2 (N=221)	82.9 (N=223)
Visually Impaired (Vision)	100.0 (N=15)	93.3 (N=14)	60.0 (N=9)	73.3 (N=11)
Blind (Vision)	100.0 (N=6)	83.3 (N=5)	66.7 (N=4)	83.3 (N=5)
Hearing Impaired (Hearing)	100.0 (N=21)	95.2 (N=20)	81.0 (N=17)	81.0 (N=17)
Deaf (Hearing)	100.0 (N=2)	100.0 (N=2)	100.0 (N=2)	100.0 (N=2)
Physical Handicap (Physical Coordination and Development)	100.0 (N=37)	94.6 (N=35)	94.6 (N=35)	83.8 (N=31)
Health/Developmentally Impaired (Physical Coordination and Development)	100.0 (N=30)	80.0 (N=24)	60.0 (N=18)	73.3 (N=22)
Speech Impaired (Speech and Language)	100.0 (N=59)	98.3 (N=58)	91.5 (N=54)	93.2 (N=55)
Specific Learning Disability (Intellectual Development)	100.0 (N=31)	74.2 (N=23)	74.2 (N=23)	74.2 (N=23)
Serious Emotional Disturbance (Social/Emotional Development)	100.0 (N=33)	72.7 (N=24)	72.7 (N=24)	66.7 (N=22)
Mentally Retarded (Intellectually or Social/ Emotional Development)	100.0 (N=35)	[2]	[3]	[4]

[1] The appropriate developmental area was determined on the basis of OCD Notice A-30-333-4, "Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start."

[2] Twenty-seven mentally retarded cases received a confirmation of handicap in intellectual development; 11 mentally retarded children received a confirmation of handicap in social/emotional development. Some of the total 35 mentally retarded cases received a confirmation of handicap in both areas. Due to this overlap, it is assumed that all mentally retarded children received a confirmation of handicap in an appropriate developmental area. This assumption also applies to functional assessments and recommendations as well.

[3] Twenty-five mentally retarded cases received a functional assessment in intellectual development; 13 mentally retarded children received an assessment in social/emotional development.

[4] Twenty-six mentally retarded cases received recommendations in intellectual development; 13 mentally retarded children received recommendations in social/emotional development.

Non-Head Start Program Diagnostic Services

Comparability of Data

For the 46 non-Head Start programs (those serving preschool handicapped children), similar information was collected concerning the diagnostic process. The same model of the ideal diagnostic process (containing a confirmation of handicap, functional assessment, and recommendations) was used to determine the type and extent of the diagnostic services available to children outside of Head Start. However, the focus of the questions asked was different. Non-Head Start responses were on the program-level only; no child-specific questions were asked. Furthermore, since non-Head Start responses pertained to diagnostic services in general, multiple responses were allowed.

Diagnostic Service Providers

In general, non-Head Start programs used the same types of providers as Head Start. For confirmation of handicap (Table 7.16), pediatricians or other licensed medical personnel provided most of the confirmations of handicap in vision (52.2%) and physical development (52.2%); speech therapists or audiologists confirmed most handicaps in hearing (52.2%) and speech and language (71.7%); and the majority of programs reported psychologists or psychiatrists as the primary providers of confirmations of disabilities in intellectual development (67.4%) and social/emotional development (54.3%). Teachers were a relatively frequent provider of confirmation services in non-Head Start programs, whereas teachers infrequently confirmed handicaps for the Head Start sample children. Similarly, non-Head Start programs more often utilized the services of disciplinary diagnostic teams. For functional assessments and recommendations (see Appendix A, Tables A7.9-A7.10) the basic pattern of relatively more predominant utilization of interdisciplinary teams and staff teachers in non-Head Start programs remains about the same. The increased utilization of teachers in non-Head Start programs in the diagnostic process reflects a basic staffing difference between

TABLE 7.16

Professionals Who Provided Confirmation of Handicap in Non-Head Start Programs by Diagnostic Area

Diagnostic Area	Provider of Confirmation						
	Psychologist/ Psychiatrist	Pediatrician Other Licensed Medical Professional	Speech Therapist/ Audiologist	Paraprofessional Medical Personnel	Interdisciplinary Team	Staff Teacher	Other 1/
Vision	2.2 (N=1)	52.2 (N=24)	2.2 (N=1)	*	13.0 (N=6)	2.2 (N=1)	23.9 (N=11)
Hearing	*	28.3 (N=13)	52.2 (N=24)	4.3 (N=2)	13.0 (N=6)	*	17.4 (N=8)
Physical Coordination and Development	8.7 (N=4)	52.2 (N=24)	*	4.3 (N=2)	26.1 (N=12)	10.9 (N=5)	23.9 (N=11)
Intellectual Development	67.4 (N=31)	4.3 (N=2)	*	*	30.4 (N=14)	8.7 (N=4)	10.9 (N=5)
Speech and Language Development	2.2 (N=1)	2.2 (N=1)	71.7 (N=33)	*	19.6 (N=9)	4.3 (N=2)	10.9 (N=5)
Social/Emotional Development	54.3 (N=25)	*	2.2 (N=1)	*	26.1 (N=12)	17.4 (N=8)	23.9 (N=11)

1/ Includes social worker and public health nurse

Note: programs were allowed to respond more than once. Percentages were derived from total number of non-Head Start programs (46).

these two types of programs. Non-Head Start programs have better qualified personnel in terms of educational backgrounds (see Chapter 4).[1]

Agency Affiliation of Diagnostic Service Providers

Another basic difference between non-Head Start programs and Head Start was that professionals affiliated with the public school system furnished diagnostic services to non-Head Start programs relatively frequently, while public school providers were used far less than providers from other agencies for the sample Head Start children. Table 7.17 shows that professionals who performed confirmations of handicaps were affiliated with the public schools in 11-17 of the non-Head Start programs. In part, non-Head Start programs used the diagnostic services of public school systems more because they were more often affiliated with the school system. Furthermore, this indicates that diagnostic services are available through the public school systems in Head Start communities, but that resource-sharing between Head Start and the schools has not taken place to the extent that it could.

Reasons for Use of Professionals/Agencies

As in the case of Head Start programs, the major reasons for using the diagnostic services of particular professionals were primarily that these people were part of an established diagnostic service and/or these professionals represented the best available service (see Appendix A, Table A7.11).

Basically, the same types of techniques were used in non-Head Start and Head Start programs to confirm handicaps (see Appendix A Tables A7.12-A7.17). Non-Head Start programs seemed to rely on their own locally-designed assessments proportionately more often, however.

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[1] Head Start teachers tend to have backgrounds in early childhood development as opposed to special education. This trend is reversed for teachers in non-Head Start programs.

TABLE 7.17

Agencies that Provided Confirmation of Handicap in Non-Head Start Programs by Diagnostic Area

Diagnostic Area	Agency						
	Private Practitioner/ Consultant	Hospital (public)	Local or State Health/ Social Services Department	Public School System	Easter Seal/ Crippled Children Assoc./ Assoc. for Retarded Children	University Affiliated Facilities	Other
Vision	34.8 (N=16)	8.7 (N=4)	8.7 (N=4)	23.9 (N=11)	4.3 (N=2)	10.9 (N=5)	8.7 (N=4)
Hearing	23.9 (N=11)	4.3 (N=2)	8.7 (N=4)	34.8 (N=16)	6.5 (N=3)	19.6 (N=9)	21.7 (N=10)
Physical Coordination and Development	41.3 (N=19)	4.3 (N=2)	8.7 (N=4)	26.1 (N=12)	4.3 (N=2)	13.0 (N=6)	26.1 (N=12)
Intellectual Development	28.3 (N=13)	2.2 (N=1)	15.2 (N=7)	30.4 (N=14)	2.2 (N=1)	13.0 (N=6)	39.1 (N=18)
Speech and Language	17.4 (N=8)	2.2 (N=1)	4.3 (N=2)	37.0 (N=17)	6.5 (N=3)	19.6 (N=9)	39.1 (N=18)
Social/Emotional Development	26.1 (N=12)	4.3 (N=2)	15.2 (N=7)	30.4 (N=14)	2.2 (N=1)	4.3 (N=2)	47.8 (N=22)

Note: programs were allowed to respond more than once. Percentages were derived from total number of non-Head Start programs (46).

This is especially noticeable in the area of speech and language where locally designed assessments were frequently used in non-Head Start programs, but they were one of the least frequently used techniques for Head Start children. The other major discrepancy between the two types of programs was the preferred technique for confirmations of handicap in social/emotional development. Head Start primarily relied on observations, whereas the non-Head Start programs primarily used formal tests, especially the Vineland Social Maturity Scale (13 of the 46 programs or 28.3%) and other, unspecified standardized tests (13 programs, 28.3%).

Parent Involvement in the Diagnostic Process

As in Head Start, parents of children in non-Head Start programs were also involved in the diagnostic process. The primary method of explaining diagnostic results in both programs was by the staff and diagnostician together, using a combination of written and verbal reports (see Table 7.18). Twenty of the 46 non-Head Start programs (43.5%) reported using staff and diagnosticians together to explain results to parents; 14 non-Head Start programs (30.4%) reported staff only; and in the remaining 12 (26.1%), diagnosticians alone explained results to parents. For those programs using both staff and diagnosticians together, 16 (80.0%) used a combination of written and verbal reports.

A comparison of Head Start and non-Head Start programs leads to some general conclusions concerning the differences in the diagnostic services provided by both. In general, non-Head Start programs seemed to use interdisciplinary teams and staff teachers as providers of diagnostic services more frequently. The public school system was also more frequently the agency responsible for diagnosis in non-Head Start programs. Finally, locally designed instruments were used for diagnostic assessments more often in non-Head Start programs than in Head Start.

TABLE 7.18

Manner in Which Diagnostic Results Are Explained to Parents in Non-Head Start Programs

Way Explained	% within Group	% of Total by Group
Not Generally Explained	*	*
Explained by diagnostician:		26.1 (N=12)
method not specified	8.3 (N=1)	
written report	*	
verbal report	41.7 (N=5)	
written and verbal report	50.0 (N=6)	
Explained by program staff:		30.4 (N=4)
method not specified	7.1 (N=1)	
written report	*	
verbal report	21.4 (N=3)	
written and verbal report	71.4 (N=10)	
Explained by staff/ diagnostician together:		43.5 (N=20)
method not specified	*	
written report	5.0 (N=1)	
verbal report	15.0 (N=3)	
written and verbal report	80.0 (N=16)	
Total**	N=46	100 (N=46)

Summary of Findings

The following is a brief summary of the major findings concerning the diagnostic services received by Head Start children and used in non-Head Start programs:

- Approximately 10 percent of the 269 sample children had no reported confirmation of handicap in the developmental area corresponding to their reported primary handicapping condition.
- By handicapping condition, the emotionally disturbed, learning disabled, and health or developmentally impaired were most likely to be identified as handicapped without appropriate diagnostic confirmation. Approximately 80 percent of the health/developmentally impaired children, 74 percent of the learning disabled, and 73 percent of the emotionally disturbed children reported a confirmation of handicap in the appropriate developmental area.
- Seriously emotionally disturbed children most frequently experienced inappropriate or belated diagnostic services, or received no diagnosis at all. Of the 33 emotionally disturbed children in the sample, there was a reported appropriate diagnostic confirmation of handicap for only 24 children, and of these, 11 children were not confirmed as handicapped in social/emotional development until January of the current program year.
- The diagnostic criteria for specific learning disabilities seemed to be complex and confusing. As a result, children identified as such were often confirmed as handicapped in a variety of developmental areas. While in part this reflects cases of multiple handicaps, it also strongly suggests that the category of learning disabled is not clear to those responsible for diagnostic classifications. Although intellectual development is the appropriate developmental area in which to confirm a child as learning disabled, the majority of these children were confirmed as handicapped in speech and language (approximately 77%), followed by intellectual development (approximately 75%), and social/emotional development (approximately 42%). Confirmations of handicap were also reported for these children in the areas of physical coordination, hearing and vision.

- Most diagnostic confirmations occurred relatively late in the program year. Including those children diagnosed prior to the current program year, by the end of October, less than half of the sample children (approximately 47% or 126 cases) had been confirmed as handicapped in the developmental area corresponding to their reported primary handicapping condition. By the end of January, approximately 68 percent of the children (N=184) had received appropriate diagnostic confirmation. While screening was provided to most of the sample children within the 90 day limit suggested by the Performance Standards, this left little time to secure diagnostic services, adjust classroom planning, and develop an individual plan of services.
- Diagnostic service providers seemed to be appropriate and qualified personnel. Physicians, speech therapists/audiologists, and psychologists/psychiatrists were the predominant types of diagnosticians. These providers were most often in private practice or associated with hospitals or clinics. Special purpose organizations and the public school system were used infrequently.
- Head Start funds (Basic Grant and Program Account 26) were the predominant source of payment for diagnostic services. Combined, these two sources of funding paid for well over half of the diagnostic confirmations in intellectual speech, and social/emotional development. A combination of joint funding arrangements, EPSDT, parent payment and unknown funding sources provided most of the confirmations of handicap in the remaining developmental areas. Inkind services on the other hand, were rarely received.
- Parents were reported to be extensively involved in the diagnostic process, both as participants and recipients of information and explanations of diagnostic results. Parents of the sample children were informed of diagnostic results in all but six cases. Head Start was actively involved in the explanation of these results; for approximately 15 percent of the children, Head Start staff was responsible for the explanation of these results to parents and in over half the cases both Head Start and the diagnostician together explained findings to the parents.
- The overwhelming majority of Head Start children, approximately 94 percent, had some type of diagnostic file although the quality of these files varied considerably.
- The same diagnosticians seemed to provide confirmations of handicaps and recommendations. However, functional assessments appeared to have been developed more often by a different professional, usually Head Start personnel.

- Even though assessments were not specifically required by the Performance Standards, functional assessments in the area of primary concern were reported for approximately 82 percent of the sample children. The quality and usefulness of these assessments varied greatly, however, from case to case.
- Approximately 83 percent of the sample children received recommendations in the developmental area corresponding to the reported primary handicapping condition.
- Non-Head Start programs used interdisciplinary teams and staff teachers to provide diagnostic services more predominantly than Head Start. Non-Head Start programs also utilized the diagnostic services of public school systems more frequently.

8

PLANNING AND CURRICULA

Once the diagnostic process has been completed and the special needs of each child identified, it is the responsibility of Head Start to ensure that necessary services are provided to each handicapped child. Because each child is a complex and unique individual, the identification of that child's special needs and the procurement of appropriate services should not be a haphazard or mechanical process. Individualized planning for each child is required if the program is to be responsive to the special needs of its handicapped children. The development of a comprehensive plan of services, the manner of planning and conducting classroom activities, and the type of curriculum used in the classroom all play an important part in the delivery of these services to handicapped children. For this reason, the manner in which Head Start prepares to meet those needs--both in the classroom as well as outside it--was examined. Specifically, the following questions are investigated in this chapter:

- How many of the Head Start handicapped children had individual plans of service? How many of them had written plans? Which components (education, health, nutrition, parent involvement, and social services) were most frequently included in children's individual plans? What types of objectives were included in the plans?
- To what extent did children's staff use the children's diagnostic files in developing their plans of service? What difficulties, if any, were encountered as a result of using diagnostic files to develop individual plans of service?

- How were classroom activities planned for the handicapped children in Head Start? How were they conducted? To what extent were individualized activities planned and conducted for the handicapped children?
- What types of written curricula, if any, were used for the handicapped children by Head Start staff?
- How do the individual plans of service, manner of planning and conducting classroom activities, and curriculum materials typically used for handicapped children in non-Head Start programs compare to those used for the sample Head Start children?

Head Start Planning and Curricula[1]

Individual Plan of Services

The procurement of necessary services for handicapped children should be based upon a comprehensive plan of services which addresses the totality of child and family needs. Thus, according to the Head Start Program Performance Standards, education, medical, dental, and mental health, nutrition and social service objectives should be identified for each child and plans made to ensure that these objectives are met. Furthermore, provisions should be made for parent involvement in each of these areas and for any special services the parents or family might require. This comprehensive plan, called an individual plan of services, should guarantee that handicapped children receive the same types of services as other Head Start children and that additional or specialized services are also provided when needed.

Respondent interpretation of the concept of an individual plan of services varies greatly from program to program. An individual plan of services was reported for 187 of the 269 children (69.5%). Of those 187 cases, program staff indicated that the plan was written for 153 children (81.8%). However, in reviewing written records, individual plans were located for only 141 children.[2] In some cases these plans were extensive; one program had complete files on each

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[1] All data in this section are child-specific.

[2] See Table 8.1.

TABLE 8.1

Manner in Which Services were Planned for Head Start Handicapped Children	
Manner of Planning	**% of Total[1]**
Child had individual plan of services	69.5 (N=187)
Child had written individual plan of services	56.9 (N=153)
Child's individual plan of services was located	52.4 (N=141)
Child only had an educational plan (and did not have individual plan of services)	4.8 (N= 13)
Components Included in Plans:	**% of Children With Individual Plans[2]**
Education	100.0 (N=141)
Health	38.3 (N= 54)
Social Services	18.4 (N= 26)
Parent Involvement	24.8 (N= 35)
Nutrition	14.2 (N= 20)
Other	7.1 (N= 10)

[1] Percentages based on the total sample of 269 children.

[2] Percentages based on the 141 children for whom individual plans of service were located.

child for each component (education, parent involvement, social services, health/nutrition), and had even color-coded the components for easy access. There were standard forms to collect baseline information (health histories, results of monitoring) as well as more extensive elaborations on specially identified problems. Another program had a comprehensive approach to needs assessment and remediation; the strengths and weaknesses of each child were identified and detailed plans were developed to foster the one and counteract the other.

These cases, however, seemed to be the exception rather than the rule. Some programs had only brief medical records (date of birth, immunizations) which they considered to be both the diagnostic file and the individual plan of services. Others viewed the individual plan as only dealing with education, or such items as lesson plans or folders containing the child's art work were presented as the individual plan. *These data and interviewer observations indicate that staff of few programs had grasped the concept of the comprehensive and interrelated nature of the components of the plan; that fewer still seemed aware of the need to use diagnostic and assessment data to formulate a plan of action to counteract the identified problems of each child; and that almost half of the sample children did not have a written comprehensive plan of services.*

Components of the Individual Plan of Services

As stated before, most programs recognized the need for some form of educational planning, often to the exclusion of the other components of the plan. Table 8.1 shows the high incidence of the education component. *Of the 141 individual plans located, all of them contained an education component.* Furthermore, separate educational plans were found for an additional 13 children who did not have an identified individual plan of services. These are included in the figures for this table. Therefore, 154 educational plans were located. The next most frequent component included in the individual plan was that of health; more than one third of the plans located (38.3%, 54 cases) included a health component. Parent involvement, social services and nutrition components occurred with lesser frequency.[1]

For those children with an individual plan of services that was located and reviewed, specific information concerning the education component was determined (see Table 8.2). A statement of annual goals[2] was found in 57.5 percent of the cases (81 of the 141 individual plans with an education component). A statement of short-term goals[3] was found even more frequently; 70.3 percent of the educational plans included in an individual plan specified short-term goals. Finally, evaluation procedures and a statement of specific educational services to be provided were found in the majority of the education components reviewed (60.3% and 63.8%, respectively).

Use of the Diagnostic File in Developing an Individual Plan of Services

Any plan of services must be individualized in order to properly meet the unique needs of each child. For handicapped children this is especially important since these children are usually in need of even more specialized services than their non-handicapped peers. Furthermore, the nature and extent of the child's disability must be taken into account when identifying appropriate and reasonable goals. To properly plan experiences and assess progress, then, the child's diagnostic file should contain critical information for planning purposes. This is one of the reasons that the three part model diagnostic process was conceived: a confirmation of handicap to

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[1] Respectively, the figures are: 24.8 percent, 18.4 percent, 14.2 percent.

[2] Defined as goals set for the school year or as general objectives that are specific to the child.

[3] Defined as more specific objectives to be achieved within a more finite time frame, such as daily, weekly or monthly.

TABLE 8.2

Education Components of Individual Service Plans for Those Children With a Service Plan

Education Component of Service Plan	Presence of Component in Plan		
	Unspecified % of Row[1]	Yes % of Row[1]	No % of Row[1]
Annual Goal	2.1 (N=3)	57.5 (N=81)	40.4 (N=57)
Short Term Goal	2.8 (N=4)	70.3 (N=99)	26.9 (N=38)
Statement of Specific Services	2.8 (N=4)	63.8 (N=90)	33.4 (N=47)
Evaluation Procedure with Objective Criteria	2.8 (N=4)	60.3 (N=85)	36.9 (N=52)

[1] Rows each sum to 141 (number of students for whom an individual service plan was located and reviewed). This fact should be carefully noted. For example, in considering the entire study sample, only 37 percent had short term goals specified in an individual plan of services.

identify the nature of the child's disability(s); a functional assessment that outlines the extent of impairment so that appropriate goals can be set; and recommendations which indicate the types of services needed.[1/] If all of these diagnostic components are present, the diagnostic file should be the prime basis for developing an individual plan of services.

Table 8.3 shows the frequency with which the diagnostic file was used to develop a plan of services. Less than half of the respondents indicated extensive use of the file; of the 187 reported cases with individual plans, the diagnostic file was extensively used to develop the plans in 78 cases. For 56 children, the diagnostic file was used only slightly, and the diagnostic file was not used at all for 50 of the 187 children with individual plans.

The major problems associated with translating the diagnostic file into a plan of services did not seem to be inherent in the file itself (see Table 8.4). When asked, respondents frequently indicated that they did not have any problems; for 71 of the 187 cases with a reported individual plan of services, respondents felt that they had no problems in using the diagnostic file to develop a service plan. Of the specific difficulties mentioned, other sources of information were found to be more useful than the diagnostic file for 34 children (18.2% of those with individual plans). Such sources may include general information on specific handicapping conditions (such as books/ pamphlets on mental retardation, etc.), or informal discussions with professionals who did not diagnose the child (special education teachers, educational consultants, etc.). Of secondary frequency, respondents indicated that they could not obtain a copy of the file. This may be simply a logistics problem (for cases in which files were maintained at a main office, but the actual center was not located near by) or due to privacy restrictions. For an additional 9.6 percent of the

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[1/] A more extensive discussion of the model diagnostic process may be found in Chapter 7.

TABLE 8.3

Extent of Use of Diagnostic File to Develop Individual Plans of Service[1]	
Frequency of Usage	% of Total
Not at All	26.7 (N=50)
Used Slightly	29.9 (N=56)
Used Extensively	41.7 (N=78)
Unspecified	1.6 (N=3)
Total	100.0 (N=187)

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[1] Includes only those children for whom an individual plan of service was reported to be available.

TABLE 8.4

Problems in Using the Diagnostic File to Develop Individual Plans of Service[1]

Problems	% of Total
No problems	38.0 (N=71)
Other sources were used more	18.2 (N=34)
Out of date information	0.5 (N=1)
Did not receive report in time	9.6 (N=18)
Terminology was too technical	0.5 (N=1)
Staff disagreed on services	0.5 (N=1)
Could not obtain a copy	14.4 (N=27)
Report was too general	5.3 (N=10)
Other	7.5 (N=14)
Unspecified	5.3 (N=10)
Total	100.0 (N=187)

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[1] Includes only those children for whom an individual plan of service was reported to be available.

children with reported individual plans, the file was not received in time to use it for planning purposes. In only a few cases was the report too general, technical or out of date for use in developing a child's individual plan.

Planning and Implementation of Activities in the Classroom

As stated before, successful mainstreaming of handicapped children involves much more than their actual physical presence in the classroom. There must be a delicate balance between individualized instruction and integration into the classroom. Each child should receive specialized instruction, yet this should not go so far as to exclude the child from classroom activities.

Table 8.5 shows that teachers planned activities that excluded the handicapped in only a few cases. For the majority of cases, activities were planned for all children the same way or were planned for all children, but modified for the handicapped children. Combined, these two approaches comprised the manner in which activities were planned for approximately 80 percent of the sample. Broken down by specific objective areas, percentages for homogeneous planning ranged from 35.3 percent in the area of communication to 49.4 percent in the objective area of self-concept development. Those cases in which general plans were made for all children with modification for specific children ranged from 37.5 percent in the area of self-concept development to 48.0 percent in the cognitive development objective area.

Similarly, Table 8.6 shows the manner in which activities were actually conducted in the classroom. Again, very few children were excluded from activities because of their handicapping condition. Most respondents indicated that activities were conducted for all children the same way. Percentages in this category ranged from 45.4 percent in the area of communications activities to 57.6 percent in the area of self-concept development activities. Of secondary frequency, teachers indicated that activities were specifically conducted for the handicapped child. Percentages in this category ranged from 30.9 percent in the self concept objective area to 42.8 percent in the area of communications activities.

TABLE 8.5

Manner of Planning Activities By Objective Area

Objective Area	Row Total % of Row	Planned for all Children the Same Way % of Row	Planned for all Children but Modified for this Child % of Row	Planned because of this Child's Handicapping Condition but not Planned for all Children % of Row	Not Planned for this Child Because of Handicap but Planned for Other Children % of Row	No Response % of Row
		Manner of Planning				
Cognitive	100.0 (N=269)	40.5 (N=109)	48.0 (N=129)	9.7 (N=26)	1.1 (N=3)	0.7 (N=2)
Communication	100.0 (N=269)	35.3 (N=95)	44.6 (N=120)	18.6 (N=50)	1.1 (N=3)	0.4 (N=1)
Self Help	100.0 (N=269)	47.2 (N=127)	40.1 (N=108)	11.5 (N=31)	0.7 (N=2)	0.4 (N=1)
Self Concept	100.0 (N=269)	49.4 (N=133)	37.5 (N=101)	11.5 (N=31)	0.4 (N=1)	1.1 (N=3)
Gross Motor	100.0 (N=269)	42.8 (N=115)	43.1 (N=116)	12.6 (N=34)	0.7 (N=2)	0.7 (N=2)
Fine Motor	100.0 (N=269)	42.0 (N=113)	44.2 (N=119)	11.9 (N=32)	0.7 (N=2)	1.1 (N=3)
Other	100.0 (N=269)	3.3 (N=9)	6.3 (N=17)	3.7 (N=10)	0.4 (N=1)	86.2 (N=232)

TABLE 8.6

Manner of Conducting Activities By Objective Area

Objective Area	Manner of Conducting Classroom Activities					
	Row Total % of Row	Conducted for all Children the Same Way % of Row	Conducted for all Handicapped Children the Same Way % of Row	Specifically Conducted for this Child % of Row	Not Conducted for this Child Because of Handicap But Done for Other Children % of Row	No Response % of Row
Cognitive	100.0 (N=269)	50.9 (N=137)	11.5 (N=31)	36.1 (N=97)	1.1 (N=3)	0.4 (N=1)
Communication	100.0 (N=269)	45.4 (N=122)	10.4 (N=28)	42.8 (N=115)	1.5 (N=4)	*
Self Help	100.0 (N=269)	55.0 (N=148)	10.8 (N=29)	33.8 (N=91)	0.4 (N=1)	*
Self Concept	100.0 (N=269)	57.6 (N=155)	10.8 (N=29)	30.9 (N=83)	0.4 (N=1)	0.4 (N=1)
Gross Motor	100.0 (N=269)	51.7 (N=139)	9.7 (N=26)	37.9 (N=102)	0.7 (N=2)	*
Fine Motor	100.0 (N=269)	50.6 (N=136)	9.7 (N=26)	38.7 (N=104)	0.7 (N=2)	0.4 (N=1)
Other	100.0 (N=269)	4.1 (N=11)	1.1 (N=3)	8.6 (N=23)	0.4 (N=1)	85.9 (N=231)

In general, there seems to be a pattern of greater individualization in the area of communications activities and objectives and a more homogeneous approach to dealing with self-concept development. *However, across all objective areas, the data indicate that individualized planning for the sample children occurred somewhat infrequently, and individualized activities were conducted for them even less frequently.* The handicapped children were treated in a similar manner to the other children in the classroom.

Curricula

The type and orientation (performance-based or experienced-based)[1/] of curricula used in Head Start programs indicate the degree to which standardized materials are utilized and the philosophical approach to teaching that is predominant. Some form of specific written curriculum was used for more than three-fourths of the sample children (79.6%; see Table 8.7). Table 8.8 shows that, across all objective areas, locally designed materials were the favored type of curriculum. The most frequent type of standardized curriculum reported was that associated with the Learning Accomplishment Profile (LAP). A combination of other types of formal curricula occurred with secondary frequency,[2/] followed by the Peabody series (especially for use in the area of communication).

[1/] An experience-based objective is a statement of the action to be taken by a teacher or instructional setting for a child that does not predict or specify the outcome of the event in terms of child behavior or skills. On the other hand, a performance-based objective is a statement for a child that specifies what he/she will be able to do or choose to do as a result of instruction.

[2/] This category may include such types of teaching materials as the Portage Project, Bank Street, or Goal Curricula.

TABLE 8.7

Number of Cases Where Specific Written Curricula Were Used	
Specific Curriculum Used	79.6 (N=214)
Specific Curriculum Not Used	18.6 (N=50)
Not Reported	1.8 (N=5)
Total	100.0 (N=269)

TABLE 8.3

Written Curricula Used by Objective Area

Objective Area					Curriculum				
	Total N* % of Row	Locally Designed Materials % of Row	Peabody % of Row	Learning Accomplishment Profile (LAP) % of Row	Montessori Curricula % of Row	School Before Six % of Row	Collier Developmental Materials/Rebus Program Curricula % of Row	Other % of Row	Curricula Not Used/ No Response % of Row
Cognitive	100 (N=269)	40.1 (N=108)	8.6 (N=23)	14.5 (N=39)	0.7 (N=2)	0.7 (N=2)	0.7 (N=2)	12.6 (N=34)	21.9 (N=59)
Communication Skills	100 (N=269)	37.2 (N=100)	13.8 (N=37)	13.8 (N=37)	0.7 (N=2)	0.7 (N=2)	0.7 (N=2)	14.9 (N=40)	18.2 (N=49)
Self-help	100 (N=269)	44.2 (N=119)	3.7 (N=10)	14.9 (N=40)	1.9 (N=5)	1.5 (N=4)	0.7 (N=2)	10.0 (N=27)	23.0 (N=62)
Self-concept	100 (N=269)	46.8 (N=126)	5.2 (N=14)	12.3 (N=33)	0.4 (N=1)	0.7 (N=2)	0.7 (N=2)	11.2 (N=30)	22.7 (N=61)
Gross motor	100 (N=269)	41.3 (N=111)	5.2 (N=14)	14.5 (N=39)	0.7 (N=2)	0.7 (N=2)	0.7 (N=2)	14.1 (N=38)	22.7 (N=61)
Fine motor	100 (N=269)	41.3 (N=111)	5.2 (N=14)	14.9 (N=40)	0.7 (N=2)	1.1 (N=3)	0.7 (N=2)	12.3 (N=33)	23.8 (N=64)
Other	100 (N=269)	7.8 (N=21)	0.4 (N=1)	4.1 (N=11)	*	*	0.4 (N=1)	2.2 (N=6)	85.1 (N=229)

Table 8.9 illustrates the orientation of the teaching materials used. A mixture of performance-based and experience-based curricula was used in more than half of those cases for which specific written curricula were reported (55.5% across all objective areas). Performance based materials were reported a total of 30.0 percent of the time, while experienced-based curricula occurred across all developmental areas for 14.5 percent of the responses. It was the impression of field staff, though, that in instances in which mixed curricula were utilized, the experiential component was often emphasized over the performance based component.

Non-Head Start Planning and Curricula[1]

Similar information was collected on planning and curricula typically used for handicapped children in non-Head Start programs and, where appropriate, general trends are compared to trends that emerged for the sample Head Start children. Direct comparisons cannot be made because the Head Start data are child-specific and the non-Head Start data are program-specific, and the response options differed as well.

Development of an Individual Plan of Services

Table 8.10 shows that all 46 of the non-Head Start programs indicated they developed an individual plan of services for their handicapped children and, with the exception of one program, these plans were written. Only seven (15.2%) non-Head Start programs reported that the individual plans contained only an education component. The remaining 39 programs (84.9%) developed individual plans of services which more-or-less comprehensively addressed the needs of each child.

The most frequent component of the plan of services reported by non-Head Start programs was that of special therapy; 84.8 percent of

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[1] All data in this section are program-specific.

TABLE 8.9

Performance or Experienced Based Curricula by Objective Area[1]

Objective Area	Total ** % or Row	Performance Based % or Row	Experience Based % of Row	Mixed % of Row
		Curriculum Orientation		
Cognitive	100 (N-212)	33.0 (N=70)	12.7 (N=27)	54.2 (N=115)
Communication Skills	100 (N=220)	29.5 (N=65)	12.7 (N=28)	57.7 (N=127)
Self-help	100 (N=206)	30.6 (N=63)	15.5 (N=32)	53.9 (N-111)
Self-concept	100 (N=208)	23.6 (N=49)	20.7 (N=43)	55.8 (N=116)
Gross Motor	100 (N=208)	32.2 (N=67)	13.0 (N=27)	54.8 (N=114)
Fine Motor	100 (N=204)	31.4 (N=64)	12.3 (N=25)	56.4 (N=115)

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[1] Includes only those children for whom specific written curricula were used.

TABLE 8.10

Manner in Which Children's Services are Planned in Non-Head Start Programs

Manner of Planning	% of Total[1]
Program develops Individual Plan of Services	100.0 (N=46)
Plan of Services is Written	97.8 (N=45)
Plan includes only an Educational Plan	15.2 (N=7)
Plan includes Education as well as other Service Areas	84.8 (N=39)
Other service areas included in Plan:	
Health	65.2 (N=30)
Social Services	67.4 (N=31)
Parent Involvement	80.4 (N=37)
Special Therapy	84.8 (N=39)
Other	23.9 (N=11)

[1] Percentages derived from total number of non-Head Start programs (46).

the programs (N=39) reported the inclusion of this component. Parent involvement was the next most frequently reported component; 37 programs (80.4%) indicated this was included in each child's plan. Health and social services were also reported as components in the individual plan by the majority of non-Head Start programs.[1]

Planning and Implementation of Activities in the Classroom

It is difficult to make comparisons between information gathered on planning and implementation of classroom activities for Head Start and non-Head Start programs, not only for reasons cited elsewhere, but also because the response categories in the respective questionnaires were slightly different. Nevertheless, *Table 8.11 shows a strong preference for individualized planning in non-Head Start programs*. Between approximately 89 and 95 percent of the non-Head Start programs reported individual planning for each handicapped child across all objectives areas. In contrast, for the Head Start cases responses were fairly evenly distributed between planning for all children the same way and planning for all children, but modifying for a particular child (see Table 8.5).

Similarly, non-Head Start implementation of activities was also heavily individualized (see Table 8.12). Across all objective areas, approximately 89 to 100 percent of all programs reported that activities were most often conducted individually for each handicapped child. While for a number of Head Start cases, this response[2] was reported, for an even larger number of cases, Head Start classroom activities were conducted for all children the same way. *The extent to which the activities were planned or conducted in an individualized*

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[1] Figures are 65.2 percent and 67.4 percent, respectively.

[2] The responses were worded in a slightly different manner. For non-Head Start the response was: "Often conducted individually for each handicapped child." The Head Start response was: "Specifically conducted for this child."

TABLE 8.11

Manner in Which Activities are Planned by Objective Area in Non-Head Start Programs

Objective Area	Manner of Planning				
	Total % of Row	Planned for Handicapped and Non-handicapped the same way % of Row	Planned for all Handicapped the same way % of Row	Planned Individually for each Handicapped child % of Row	No Response % of Row
Cognitive	100 (N=46)	4.3 (N=2)	6.5 (N=3)	89.1 (N=41)	*
Communication	100 (N=46)	2.2 (N=1)	2.2 (N=1)	95.7 (N=44)	*
Self-help	100 (N=46)	4.3 (N=2)	4.3 (N=2)	91.3 (N=42)	*
Self-concept	100 (N=46)	4.3 (N=2)	4.3 (N=2)	89.1 (N=41)	2.2 (N=1)
Gross Motor	100 (N=46)	2.2 (N=1)	8.7 (N=4)	89.1 (N-41)	*
Fine Motor	100 (N=46)	2.2 (N=1)	6.5 (N=3)	91.3 (N=42)	*
Other	100 (N=46)	*	2.2 (N=1)	30.4 (N=14)	67.4 (N=31)

TABLE 8.12

Manner in Which Activities are Conducted by Objective Area in Non-Head Start Programs

Objective Area	Manner of Conducting Activities				
	Total % of Row	Conducted for Handicapped and Non-Handicapped the same way % of Row	Conducted for all Handicapped the same way % of Row	Often Conducted Individually for each Handicapped child % of Row	No Response % of Row
Cognitive	100 (N=46)	2.2 (N=1)	8.7 (N=4)	89.1 (N-41)	*
Communication	100 (N=46)	*	*	100.0 (N=46)	*
Self-help	100 (N=46)	4.3 (N=2)	2.2 (N=1)	93.5 (N=43)	*
Self-concept	100 (N=46)	4.3 (N=2)	4.3 (N=2)	89.1 (N=41)	2.2 (N=1)
Gross Motor	100 (N=46)	*	8.7 (N=4)	91.3 (N=42)	*
Fine Motor	100 (N=46)	*	4.3 (N=2)	89.1 (N=41)	6.5 (N=3)
Other	100 (N=46)	2.2 (N=1)	*	6.5 (N=3)	91.3 (N=42)

3.21

manner did not depend on whether the program provided a mainstream setting for its handicapped children.[1] *This finding indicates that the fact that Head Start programs mainstream handicapped children cannot be considered to inhibit their ability to individualize classroom activities.*

Similar to the figures for Head Start,[2] most of the non-Head Start programs used specific written curricula (78.3%). Between 37 and 50 percent of the non-Head Start programs reported using locally-designed materials for teaching curriculum (see Table 8.13). This was also the most preferred type of curriculum for the Head Start children.

While the types of teaching materials were similar for both programs, the orientation of the curriculum was slightly different. On the average, Head Start programs used materials that were a mixture of performance and experience-based. In contrast, Table 8.14 shows a proportionately greater preference for performance-based curricula in non-Head Start programs; the average for all objective areas was 44.4 percent performance-based, 42.0 percent mixed, and 14.5 percent experience-based.

Summary of Findings

The following is a summary of the major findings concerning planning and curricula in Head Start and non-Head Start programs:

- There was some confusion surrounding the concept of an individual plan of services. Only half of the Head Start children had individual plans of service, and these varied greatly in quality and comprehensiveness.
- A child's diagnostic file was not always used to develop an individual plan of services for the handicapped children in Head Start. The diagnostic file was used extensively in the development of service plans for only 78 of the 269 sample children.

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[1] Conclusion from a comparison of 13 non-Head Start programs with a classroom mainstreaming component with non-Head Start programs that did not mainstream in the classroom.

[2] See Table 8.7.

TABLE 8.13

Distribution of Written Curricula used by Objective Area in Non-Head Start Programs

Objective Area	Curriculum						
	Total ** % of Row	Locally Designed Materials % of Row	Peabody % of Row	Learning Accomplishment Profile (LAP) % of Row	Other % of Row	Portage Project Curriculum % of Row	Written Curricula Not Used % of Row
Cognitive	100 (N=46)	37.0 (N=17)	8.7 (N=4)	4.3 (N=2)	19.6 (N=9)	8.7 (N=4)	21.7 (N=10)
Communication	100 (N=46)	39.1 (N=18)	10.9 (N=5)	4.3 (N=2)	15.2 (N=7)	8.7 (N=4)	21.7 (N=10)
Self-help	100 (N=46)	50.0 (N=23)	2.2 (N=1)	4.3 (N=2)	10.9 (N=5)	8.7 (N=4)	23.9 (N=11)
Self-concept	100 (N=46)	45.7 (N=21)	2.2 (N=1)	4.3 (N=2)	10.9 (N=5)	4.3 (N=2)	32.6 (N=15)
Gross Motor	100 (N=46)	39.1 (N=18)	4.3 (N=2)	6.5 (N=3)	17.4 (N=8)	8.7 (N=4)	23.9 (N=11)
Fine Motor	100 (N=46)	39.1 (N=18)	4.3 (N=2)	6.5 (N=3)	17.4 (N=8)	8.7 (N=4)	23.9 (N=11)
Other	100 (N=46)	19.6 (N=9)	2.2 (N=1)	2.2 (N=1)	2.2 (N=1)	2.2 (N=1)	71.7 (N=33)

TABLE 8.14

Distribution of Performance or Experienced Based Curricula by Objective Area for those Non-Head Start Programs in which Specific Written Curricula were Used

Objective Area	Curriculum Orientation			
	Total ** % of Row	Performance Based % of Row	Experience Based % of Row	Mixed % of Row
Total	100 (N=207)	44.4 (N=92)	13.5 (N=28)	42.0 (N=87)
Cognitive	100 (N=36)	38.9 (N=14)	13.9 (N=5)	47.2 (N=17)
Communication Skills	100 (N=36)	44.4 (N=16)	11.1 (N=4)	44.4 (N=16)
Self-help	100 (N=35)	45.7 (N=16)	17.1 (N=6)	37.1 (N=13)
Self-concept	100 (N=32)	37.5 (N=12)	15.6 (N=5)	46.9 (N=15)
Gross motor	100 (N=34)	50.0 (N-17)	11.8 (N=4)	38.2 (N=13)
Fine Motor	100 (N=34)	50.0 (N=17)	11.8 (N=4)	38.2 (N=13)

- Classroom activities were not necessarily planned or implemented in an individualized manner for the Head Start handicapped children. A mixture of full integration and individualized instruction in particular objective areas seemed to be the general pattern. Children were rarely excluded from activities due to their handicapping condition. Since the non-Head Start program predominantly individualized their activities regardless of whether they mainstreamed their children, the fact that Head Start mainstreams does not appear to explain the relatively lower rate of individualized activities.
- Locally designed materials with a mixture of performance- and experience-based criteria were the favored curricula in Head Start programs.
- Non-Head Start programs had a much higher incidence of reported individual plans of service; a reported higher degree of individualized instruction; and showed a preference for performance-based curricula relative to Head Start programs.

9

MONITORING ACTIVITIES

One of the critical activities related to the process of providing services to handicapped children according to an individualized plan is monitoring. Monitoring can be described as the process by which the services provided to the child are evaluated in terms of the child's response to these services. A child's plan of services can then be modified on the basis of results of monitoring activities. That is, assessment of child progress, accomplished by monitoring, is intended to feed into an evolving plan of services. The Head Start Program Performance Standards indicate that procedures shall be used for "ongoing observation, recording and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs" (p.10). These procedures, which are referred to as monitoring activities, shall "be used for reviewing each child's progress and modifying the program when indicated." The following questions related to monitoring activities are investigated in the context of this chapter:

- For how many of the sample handicapped children in Head Start were monitoring activities conducted?
- What types of techniques were used to monitor the progress of the sample handicapped children? What professionals most frequently conducted monitoring activities?
- To what extent were the sample handicapped children's individual plans of service modified as a result of monitoring activities?
- How do the monitoring activities typically conducted in the non-Head Start programs compare to the activities conducted for the sample handicapped children in Head Start?

All Head Start data are child-specific and all non-Head Start data are program-specific.

Head Start Monitoring

Extent of Monitoring Activities

Program staff reported that regular monitoring or progress reports were completed for 263 of the sample children (97.8%); and, although the field staff located monitoring or progress reports in children's files for slightly fewer children (81.8%), it is nonetheless apparent that *monitoring activities of some type were conducted for the majority of the children.*

Type of Monitoring Activities Conducted

Table 9.1 indicates that unstructured observation was, overall, the most frequently used monitoring technique (used for 75.5% of the sample). Teacher or center designed assessments and parent reports were each used for approximately one-half of the children (54.6% and 47.6%, respectively), whereas assessments that were part of a curriculum package or other formal tests were used for only one-quarter to one-third of the sample (34.2% and 24.5%, respectively). *Thus, Head Start programs used unstructured or informal monitoring techniques for far more children than for whom they used standardized tests or structured check lists.* Furthermore, the informal techniques such as observation and parent report were used far more frequently (i.e., weekly or monthly) than the standardized tests or curriculum-specific assessments. The latter techniques were primarily used no more than twice a year.

Monitoring techniques were administered by predominantly one type of professional, the teacher (Table 9.2). Of the 514 instances of monitoring reported in the sample of 269 children, 77.6 percent (399 instances) were conducted by the child's Head Start teacher. Other types of professionals were very infrequently used to monitor children's progress.

TABLE 9.1

Monitoring Techniques Used by Head Start Programs by Frequency of Application

Frequency	Formal (Standardized) Tests % of Column	Assessments That Are Part of Specific Curriculum Package % of Column	Teacher/Center Designed Assessment % of Column	Unstructured Observation % of Column	Parent Report % of Column	Other % of Column
Total[1/]	24.5 (N=66)	34.2 (N=92)	54.6 (N=147)	75.5 (N=203)	47.6 (N=128)	13.8 (N=37)
Weekly	9.1 (N=6)	14.1 (N=13)	19.0 (N=28)	56.2 (N=114)	25.8 (N=33)	18.9 (N=7)
Monthly	*	15.2 (N=14)	17.7 (N=26)	7.9 (N=16)	28.1 (N=36)	37.8 (N=14)
Twice a Year	51.5 (N=34)	25.0 (N=23)	10.9 (N=16)	0.5 (N=1)	20.3 (N=26)	13.5 (N=5)
Yearly	12.1 (N=8)	4.3 (N=4)	2.0 (N=3)	*	*	*
Other	27.3 (N=18)	41.3 (N=38)	50.3 (N=74)	35.2 (N=72)	25.8 (N=33)	29.7 (N=11)

[1/] Percentages in the "total" row are based on a sample size of 269 children and, thus, reflect the percentage of the sample monitored using each technique. All other percentages are based on column-specific totals rather than on the total number of sample children.

TABLE 9.2

Professionals Who Provided Monitoring Services to Head Start Children[1]	
Head Start Teacher	77.6 (N=399)
Speech Pathologist	5.6 (N=29)
Psychologist/Psychiatrist	2.1 (N=11)
Nurse	1.9 (N=10)
Physical/Occupational Therapist	1.9 (N=10)
Social Worker/Certified Special Education Teacher	1.6 (N=8)
Opthomologist/Optometrist/ Audiologist	1.4 (N=7)
Physician	1.4 (N=7)
Other	6.4 (N=33)
Total**	100 (N=514)

[1] Children were often monitored more than once during the program year; as such, there were 514 instances of monitoring located in the sample children's files, and the percentages are based on this figure.

Modification of Individual Service Plans

Program staff indicated that individual plans of services were modified as a result of monitoring activities in 172 cases (63.9% of the sample children). However, according to staff reports, only 187 children had individual plans and, therefore, plans were modified due to monitoring activities for almost all of the children who had individual plans (91.8%). These data indicate that, on the whole, results of monitoring activities were being used to modify the children's plans of service in accordance with their progress. However, the data do not permit inferences about the extent to which plans of service were appropriately modified as a result of monitoring or the quality of the monitoring activities themselves.

Non-Head Start Monitoring Activities

All of the non-Head Start programs indicated that they regularly monitored the progress of the handicapped children in their programs (100.0%). The pattern of monitoring techniques used by non-Head Start programs is similar to the pattern used by Head Start programs (see Table 9.3). That is, teacher/center designed assessments and unstructured observation techniques were most frequently used (76.1% and 65.2% of the programs, respectively), followed by parent report (60.9%). Formal tests and curriculum-specific assessments were used less frequently than the other techniques (54.3% and 39.1% of the programs, respectively).

Summary of Findings

- Head Start program staff indicated that monitoring activities were conducted for virtually all of the sample children, although monitoring reports were located in children's files in slightly fewer cases (81.8%).
- Unstructured and informal monitoring techniques were used far more frequently for the Head Start sample children than formal standardized tests or other structured techniques. Children's teachers usually conducted monitoring activities.

TABLE 9.3

Monitoring Techniques Used by Non-Head Start Programs by Frequency of Application

Frequency	Monitoring Technique					
	Formal (Standardized) Tests % of Column	Assessments That Are Part of Specific Curriculum Package % of Column	Teacher/Center Designed Assessment % of Column	Unstructured Observation % of Column	Parent Report % of Column	Other % of Column
Total[1/]	54.3 (N=25)	39.1 (N=18)	76.1 (N=35)	65.2 (N=30)	60.9 (N=28)	28.3 (N=13)
Weekly	*	*	20.0 (N=7)	56.7 (N=17)	7.1 (N=2)	7.7 (N=1)
Monthly	8.0 (N=2)	5.6 (N=1)	20.0 (N=7)	10.0 (N=3)	32.1 (N=9)	30.8 (N=4)
Twice a Year	40.0 (N=10)	38.9 (N=7)	14.3 (N=5)	*	7.1 (N=2)	*
Yearly	28.0 (N=7)	5.6 (N=1)	*	*	3.6 (N=1)	15.4 (N=2)
Other	24.0 (N=6)	50.0 (N=9)	45.7 (N=16)	33.3 (N=10)	50.0 (N=14)	46.2 (N=6)

[1/] Percentages in the "total" row are based on a sample size of 46 programs and, thus, reflect the percentage of the programs that used each type of technique for monitoring purposes. All other percentages within each column are based on the total within the column rather than on the total number of non-Head Start programs.

- Plans of service of almost all of the children who had such plans were modified as a result of monitoring (91.8%).
- All of the non-Head Start programs reported they regularly monitored the progress of handicapped children in their programs. Most frequently reported monitoring techniques were similar to those used for Head Start children.

10

SERVICE PROVIDERS

To facilitate comprehensive service delivery to handicapped children in a mainstream setting, Head Start often supplements the services of the program staff with services from a wide variety of professionals. These professionals are primarily used to conduct screening and diagnostic procedures, and they also participate in the delivery of health, therapeutic, and/or educational services to Head Start handicapped children.

The examination of the provision of services to children and the professionals/agencies used for service delivery reflects the interest of the staff of the Administration for Children, Youth and Families in a child-centered approach to service delivery. A child-centered approach is characterized by a willingness to go beyond the boundaries of one's own program to secure the most appropriate services for the children (i.e., coordination with external agencies and professionals). Children who are served by a variety of professionals appropriate to their needs may be considered to be recipients of child-centered services. In contrast, an agency-centered approach is characterized, in part, by a concern with one's own agency "turf" and an unwillingness or inability to cooperate with other agencies for securing services for handicapped children.

This chapter provides information on service providers used by the sample Head Start programs from two perspectives. First, the type of professionals used and the type of services provided to the sample children is presented. These data are child-specific. Secondly, the sample of service providers is described; these data are similar to the first data set but are service provider-specific. Finally, the types of service providers generally used by non-Head Start programs are described; these data are program-specific. The questions which are investigated in this chapter are:

- How many handicapped children in the Head Start sample received services from specialists at least once during the program year? What types of specialists provided services to the children? What types of services did they provide?
- How many handicapped children in the Head Start sample received services from specialists on at least a weekly basis? With what agencies were the regular service providers affiliated? How were their services secured and who paid for their services?
- How many sample handicapped children who did not receive services from a Head Start staff member with a degree in special education also did not receive regular (i.e., weekly) services from outside professionals?
- How do the services that were provided by specialists to the sample of handicapped children in Head Start compare to services that were typically provided to handicapped children in the non-Head Start programs?

Head Start Service Providers

Professionals Who Provided Services to Sample Children

Head Start staff indicated the number and type of professionals who provided services to the sample children, their areas of involvement, Head Start's role in securing their services, and the manner in which these professionals were paid. Data in this section are based on a sample of 269 children, and are child-specific.

For almost all of the sample children, Head Start utilized professional specialists for provision of services at least once during the program year (243 or 90.3%). Table 10.1 presents the area of specialization of the professionals by the percentage of children to whom they provided services (see far left column). Nurses and speech pathologists/therapists provided services most frequently (to 51.7%

TABLE 10.1

Professionals Used for Provision of Services to Study Children and Area of Involvement

Professional	Total Children Served [1]	Involvement Area [2]						
		Works with Child at Another Site	Works with Child in the Classroom	Trains/Consults with Teacher	Trains Parents	Evaluates Child's Progress	Observes in Classroom	Other
Physician	44.2 (N=119)	76.5 (N=91)	10.9 (N=13)	16.8 (N=20)	14.3 (N=17)	53.8 (N=64)	5.0 (N=6)	7.6 (N=9)
Nurse	51.7 (N=139)	34.5 (N=48)	56.8 (N=79)	66.2 (N=92)	59.0 (N=82)	68.3 (N=95)	53.2 (N=74)	7.9 (N=11)
Psychologist/ Psychiatrist	41.3 (N=111)	42.3 (N=47)	31.5 (N=35)	73.0 (N=81)	36.0 (N=40)	77.5 (N=86)	55.8 (N=62)	5.4 (N=6)
Speech Pathologist/ Therapist	49.4 (N=133)	68.4 (N=91)	50.4 (N=67)	67.7 (N=90)	53.4 (N=71)	88.7 (N=118)	55.6 (N=74)	3.8 (N=5)
Social Worker	40.1 (N=108)	18.5 (N=20)	38.9 (N=42)	63.9 (N=69)	78.7 (N=85)	35.2 (N=38)	54.6 (N=59)	13.0 (N=14)
Nutritionist/ Dietician	12.3 (N=33)	9.1 (N=3)	21.2 (N=7)	100.0 (N=33)	72.7 (N=24)	45.4 (N=15)	45.4 (N=15)	*
Certified Special Education Teacher	22.3 (N=60)	55.0 (N=33)	36.7 (N=22)	65.0 (N=39)	55.0 (N=33)	75.0 (N=45)	61.7 (N=37)	8.3 (N=5)
Physical Therapist	14.9 (N=40)	87.5 (N=35)	27.5 (N=11)	60.0 (N=24)	55.0 (N=22)	62.5 (N=25)	30.0 (N=12)	5.0 (N=2)
Occupational Therapist	8.2 (N=22)	90.9 (N=20)	31.8 (N=7)	68.2 (N=15)	68.2 (N=15)	95.4 (N=21)	27.3 (N=6)	*
Opthamologist/ Optometrist	12.6 (N=34)	91.2 (N=31)	2.9 (N=1)	29.4 (N=10)	29.4 (N=10)	52.9 (N=18)	*	8.8 (N=3)
Other Specialist	23.8 (N=64)	51.6 (N=33)	59.4 (N=38)	71.9 (N=46)	50.0 (N=32)	78.1 (N=50)	68.8 (N=44)	4.7 (N=3)

[1] Percentages for this column based on total number of children in the sample (N=269). For example, 119 children (44.2%) were served by physicians.

[2] Percentages for each row of involvement areas based on number of children served by the corresponding professional type. For example, 91 of the 119 children who were served by a physician, or 76.5 percent, were served at another site.

and 49.4% of the sample, respectively), although physicians, psychologists/psychiatrists, and social workers also provided services to a large number of children (to 44.2%, 41.3%, and 40.1% of the sample, respectively). These five groups of specialists were the primary service providers for the sample children, although a broad spectrum of other types of specialists provided services to the sample children as well. The area of service provision with which the specialists were involved varies by the professional type, although, on the whole, all potential involvement areas were well-represented. Across professional categories, the specialists were most frequently involved in the following areas:

- working with children at sites other than the classroom
- evaluating child progress
- training or consulting with teachers

This indicates that the children who received any services from professionals predominantly received direct one-to-one services, although the second and third most predominant areas of involvement related to indirect service delivery. Further, the high percentages in the "works with child at another site" and "works with child in the classroom" columns (Table 10.1) indicate that almost all of the sample children received one-to-one services from specialists at some point during the program year.

Although almost all of the sample children received services at least once from specialists/professionals, *less than half of them (110 or 40.9%) received services on a regular and frequent basis - that is, as part of their weekly schedule*. The following discussion relates to the professionals who provided services to the sample children (N=110) on at least a weekly basis, which excludes providers of one-time services such as screening or diagnosis.

The agency affiliations of the regular service providers are presented for each service area in Table 10.2. The predominant agency affiliation varies by service area. Professionals who provided educational instruction were most frequently affiliated with the

TABLE 10.2

Services Provided to Study Children by Agency [1]

	Service Area						
Agency	Day Care % of Column	Educational Instruction % of Column	Family Counseling % of Column	Medical/ Dental Treatment % of Column	Occupational/ Physical Therapy % of Column	Other Therapy Related to Child's Handicap % of Column	Other % of Column
Total	100.0 (N=5)	100.0 (N=32)	100.0 (N=29)	100.0 (N=25)	100.0 (N=19)	100.0 (N=56)	100.0 (N=16)
Private Practitioner/ Consultant	*	*	10.4 (N=3)	60.0 (N=15)	*	21.4 (N=12)	6.2 (N=1)
Public Hospital	*	*	13.8 (N=4)	16.0 (N=4)	5.3 (N=1)	8.9 (N=5)	*
Public or State Health Department	*	6.2 (N=2)	3.4 (N=1)	*	10.4 (N=2)	1.8 (N=1)	*
Social Services Department	40.0 (N=2)	3.1 (N=1)	31.0 (N=9)	8.0 (N=2)	*	5.4 (N=3)	6.3 (N=1)
Public School System	20.0 (N=1)	62.5 (N=20)	10.4 (N=3)	*	15.8 (N=3)	8.9 (N=5)	50.0 (N=8)
Easter Seal Agency	*	*	3.4 (N=1)	*	5.3 (N=1)	5.4 (N=3)	*
Crippled Children Association	*	*	*	*	31.6 (N=6)	*	*
Association for Retarded Children	*	*	*	*	*	*	*
BEH First Chance Project	*	*	*	*	*	*	*
University Affiliated Facility	*	*	6.9 (N=2)	*	*	7.1 (N=4)	*
Other	40.0 (N=2)	28.2 (N=9)	20.7 (N=6)	16.0 (N=4)	31.6 (N=6)	41.1 (N=23)	37.5 (N=6)

[1] Includes only those children who received services from professionals as part of their weekly schedule (N=110). Each child may have received more than one type of service (i.e., may be represented in more than one column).

public school system (62.5%). Professionals affiliated with social services departments were the most frequent providers of family counseling services (31.0%). Medical or dental treatment was most frequently provided by private practitioners or consultants (physicians) (60.0%), and professionals employed by the Cripped Children Association were the most frequent providers of occupational or physical therapy (31.6%).

Professionals who provided services to sample children on at least a weekly basis were paid from a variety of sources (see Table 10.3). Across service areas, *professionals' regular services were most often paid for by the providing agency,*[1/] and an additional small percentage of the services were provided on an in-kind basis. Thus, the external services regularly received by the Head Start children were generally funded by neither the Head Start program nor the children's parents.

Table 10.4 presents the role that Head Start played in securing the services of specialists in each of the service areas. With the exception of occupational/physical therapy, *services for the children were most frequently instigated by Head Start.* Services were rarely initiated by another agency and coordinated with Head Start, except in the area of occupational/physical therapy. These data indicate that for services provided on at least a weekly basis, Head Start primarily initiated service provision. If the service was initiated by a source other than Head Start, these services were not often coordinated with Head Start.

Data presented in Chapter 4 indicated that few of the teachers, aides, or educational coordinators who served the sample handicapped children had a college or graduate degree in special education. The above data indicated that fewer than half of the children received weekly services from specialists external to Head Start. Following these two sets of findings further, *over half of the children had no classroom staff trained in special education and did not receive*

[1/] In effect, this is an in-kind service to Head Start.

TABLE 10.3

Services Provided to Study Children by Source of Funding [1]

	Service Area						
Funding Source	Day Care % of Column	Educational Instruction % of Column	Family Counseling % of Column	Medical/ Dental Treatment % of Column	Occupational/ Physical Therapy % of Column	Other Therapy Related to Child's Handicap % of Column	Other % of Column
Total	100.0 (N=5)	100.0 (N=32)	100.0 (N=29)	100.0 (N=25)	100.0 (N=19)	100.0 (N=56)	100.0 (N=16)
Head Start bears full cost	*	*	13.8 (N=4)	36.0 (N=9)	10.5 (N=2)	28.6 (N=16)	12.5 (N=2)
Services provided in-kind (services not invoiced)	*	3.1 (N=1)	6.9 (N=2)	4.0 (N=1)	5.3 (N=1)	3.6 (N=2)	25.0 (N=4)
Services paid for by providing agency	20.0 (N=1)	68.8 (N=22)	41.4 (N=12)	12.0 (N=3)	31.6 (N=6)	14.3 (N=8)	43.8 (N=7)
Services paid *in part* by Head Start	20.0 (N=1)	9.4 (N=3)	10.3 (N=3)	*	10.5 (N=2)	3.6 (N=2)	*
Parents pay for services (all or part)	40.0 (N=2)	*	3.4 (N=1)	12.0 (N=3)	5.3 (N=1)	16.0 (N=9)	*
Other	20.0 (N=1)	18.7 (N=6)	24.2 (N=7)	36.0 (N=9)	36.8 (N=7)	33.9 (N=19)	18.7 (N=3)

[1] Includes only those children who received services from professionals as part of their weekly schedule (N=110). Each child may have received more than one type of service (i.e., may be represented in more than one column).

TABLE 10.4

Services Provided to Study Children by Role of Head Start [1]

	Service Area						
Role of Head Start	Day Care % of Column	Educational Instruction % of Column	Family Counseling % of Column	Medical/ Dental Treatment % of Column	Occupational/ Physical Therapy % of Column	Other Therapy Related to Child's Handicap % of Column	Other % of Column
Total	100.0 (N=5)	100.0 (N=32)	100.0 (N=29)	100.0 (N=25)	100.0 (N=19)	100.0 (N=56)	100.0 (N=16)
Services initiated prior to enrollment; no Head Start involvement or coordination	60.0 (N=3)	15.6 (N=5)	20.7 (N=6)	24.0 (N=6)	47.4 (N=9)	12.5 (N=7)	6.2 (N=1)
Services provided at the instigation of Head Start; included in individual plan of services as a line item	20.0 (N=1)	28.1 (N=9)	20.7 (N=6)	24.0 (N=6)	15.8 (N=3)	48.2 (N=27)	37.5 (N=6)
Services provided at the instigation of Head Start; not formally a part of individual plan of services	20.0 (N=1)	15.6 (N=5)	24.1 (N=7)	24.0 (N=6)	*	16.1 (N=9)	37.5 (N=6)
Services provided at the instigation of another agency; coordinated with Head Start and included in individual plan of services	*	12.6 (N=4)	6.9 (N=2)	8.0 (N=2)	15.8 (N=3)	12.5 (N=7)	*
Services provided at the instigation of another agency; but not formally included in individual plan of services	*	3.1 (N=1)	6.9 (N=2)	4.0 (N=1)	15.8 (N=3)	1.8 (N=1)	12.6 (N=2)
Services provided after enrollment, instigated by other agency, and no Head Start involvement/ coordination	*	3.1 (N=1)	3.4 (N=1)	*	*	3.6 (N=2)	*
Other	*	21.9 (N=7)	17.3 (N=5)	16.0 (N=4)	5.2 (N=1)	5.3 (N=3)	6.2 (N=1)

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[1] Includes only those children who received services from professionals as part of their weekly schedule (N=110). Each child may have received more than one type of service (i.e., may be represented in more than one column).

regular, weekly services from specialists external to Head Start. This figure is slightly lower for severely/profoundly handicapped children, but nevertheless, almost half of these children - who are presumably the ones most in need of specialized services - did not receive them on a regular basis. (See Table 10.5.) One-third of the children had no classroom staff with degrees in special education but received services from outside professionals on at least a weekly basis. Finally, approximately 10 percent of the children received services from classroom staff with special education degrees. *These data indicate that a majority of the sample children in Head Start did not regularly receive services from specialists or special education professionals on a regular, established basis. They were, instead, often placed in a mainstream setting without the benefit of specialized supportive educational services.*

Characteristics of Professional Service Providers

Service provider information was collected from the external providers themselves. Field staff were able to contact and interview 265 professionals who provided and/or continue to provide services to the handicapped children in the study sample. For some children, more than one provider was interviewed, and some providers served more than one of the children in the sample. However, not all of the sample children were represented by the sample of service providers. This occurred because of difficulty in locating/contacting/interviewing the appropriate service providers[1] and not necessarily because the children were not served by professionals external to the Head Start staff. Therefore, the tables within this section related to service providers' characteristics are based on the number of providers interviewed (N=265). Tables that relate to the services that

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[1] Program staff provided the field staff with the names and telephone numbers of specialists who provided services to the sample children. Field staff then attempted to interview the specialists by telephone. However, they were not able to conduct and/or complete interviews with all service providers because of scheduling conflicts, inability to reach them, change of jobs, refusals, etc. The types of professionals most difficult to contact were physicians and other medically-oriented professionals.

TABLE 10.6

Type of Services Provided By Specialists	
Services Provided	% of Total
Diagnosis	54.0 (N=252)
Screening	51.6 (N=241)
Therapy	23.8 (N=111)
Health Services	21.4 (N=100)
Educational Services	22.3 (N=104)
Parental Counseling/Training	42.6 (N=199)
Teacher/Staff Training specific to child	39.0 (N=182)
Other	6.2 (N=29)

NOTE: Percentages are based on the total number of service provider cases (N=467), rather than the number of children (N=269) or the number of service providers (N=265), because some children are represented by more than one provider and some providers represent more than one child.

the specialists provided to children, however, are based on the number of children to whom each interviewed professional provided services (N=467, except for tables that only consider service providers in a given area), since an individual professional may have provided services to more than one child and each child may be represented by more than one service provider. For convenience, this sample size will be referred to as service provider cases. This section describes the range of services provided by the sample of specialists, how they were paid, and how they become involved with Head Start. None of the data reported in this section are child-specific.

As Table 10.6 indicates, the professionals who provided services to the sample children were primarily used to provide screening and diagnostic services (54.0 and 51.6%, respectively, of the service provider cases). Secondarily, the professionals were used to provide training to parents or Head Start staff (42.6 and 39.0%, respectively). Professionals were least often used to directly provide services to the child (therapeutic, health, or educational services; 23.8, 21.4, and 22.3%, respectively). Tables 10.7 - 10.11 describe the subareas within each service area in which professionals were primarily involved, and the most frequent areas of involvement are highlighted below.

- Professionals who provided diagnostic services most often participated in confirmation of a child's handicap, recommendations related to the handicap, or functional assessment in the area of the handicap.
- Health service providers primarily performed regular medical/dental examinations and follow-ups.
- Providers of educational services most frequently developed educational objectives or an instructional program for children.
- Professionals who counseled or trained parents most often assisted in the interpretation of their child's diagnostic file.
- Professionals who provided training to Head Start staff most frequently trained in 1) working with specific handicapping conditions; 2) individualized instructional techniques; 3) understanding handicapped children and their problems; and 4) screening and assessment.

TABLE 10.5

Specialist Services Received by Head Start Handicapped Children

Staffing[1] and External Services	% of Children	% of Severely/ Profoundly Handicapped Children
Special education staff and receive weekly specialist services	7.8 (N=21)	5.0 (N=4)
Special education staff and do not receive weekly specialist services	2.6 (N=7)	1.2 (N=1)
No special education staff and receive weekly specialist services	33.1 (N=89)	47.5 (N=38)
No special education staff and do not receive weekly specialist services	56.1 (N=131)	46.3 (N=37)
No response	0.4 (N=1)	* (N=0)
Total	100.0 (N=269)	100.0 (N=80)

[1] Includes classroom teachers and aides and educational coordinators

TABLE 10.7

Diagnostic Processes in Which Service Providers Participated	
Process	% of Total[1]
Confirmation of handicap	84.5 (N=213)
Functional assessment in area of handicap	73.8 (N=186)
General functional assessment	43.7 (N=110)
Recommendations in area of handicap	78.2 (N=197)
General recommendations	56.3 (N=142)

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[1] Percentages are based on the total number of service provider cases involved in the diagnostic process (N=252). Each case may be represented by more than one process area.

TABLE 10.8

Types of Health Services Provided by Service Providers	
Service	% of Total [1]
Regular medical/dental examinations and follow-up	70.0 (N=70)
Prescription/monitoring of pharmaceuticals	40.0 (N=40)
Surgical services (specific to handicap)	18.0 (N=18)
Nutritional planning and monitoring	31.0 (N=31)
Treatment of allergies and handicap-related syndrones	11.0 (N=11)
Prosthetic services	3.0 (N=3)
Other	44.0 (N=44)

[1] Percentages are based on the number of service provider cases involved in provision of health services (N=100). Each case may be represented by more than one service area.

TABLE 10.9

Type of Educational Services Provided by Service Providers

Service	% of Total[1]
Developed educational objectives/program	82.7 (N=86)
Worked with child at Head Start Center	55.8 (N=58)
Worked with child at home/location other than Head Start Center	30.8 (N=32)
Conducted educational assessments	50.0 (N=52)
Other	40.4 (N=42)

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[1] Percentages based on number of service provider cases involved in provision of educational services (N=104). Each case may be represented by more than one service area.

TABLE 10.10

Type of Parental Counseling/Training Provided by Service Providers	
Training Area	% of Total[1/]
Interpretation of diagnostic file	72.9 (N=145)
Nutritional/health counseling	26.6 (N=53)
Behavior management	52.3 (N=104)
Family relations	47.7 (N=95)
Availability of community resources	49.7 (N=99)
Instructional techniques	49.7 (N=99)
Other	11.6 (N=23)

[1/] Percentages are based on the number of service provider cases involved in provision of parental counseling/training (N=199). Each case may be represented by more than one training area.

TABLE 10.11

Types of Head Start Staff Training Provided by Service Providers	
Training Area	% of Total[1]
Knowledge of Head Start Performance Standards	19.8 (N=36)
Behavior management/modification	53.3 (N=97)
Individualized instructional techniques	70.3 (N=128)
Preparation of individual learning objectives	46.2 (N=84)
Working with parents	54.4 (N=99)
Strategies for recruitment of handicapped children	21.4 (N=39)
Screening and assessment	61.5 (N=112)
Theory and practice of mainstreaming	22.0 (N=40)
Strategies for working with specific handicapping conditions	72.0 (N=131)
Understanding handicapped children and their special problems	66.5 (N=121)

[1] Percentages are based on the number of service provider cases involved in provision of Head Start staff training (N=182). Each case may be represented by more than one training area.

Payment of Professional Service Providers

Of the 265 professionals interviewed, 187 were paid for their services (70.6%), 69 were not paid (26.0%), and 9 did not respond to the question (3.4%). Of those who were paid for their services, 80 (42.8%) were paid in entirety by Head Start, 45 (24.1%) were paid in entirety by their agency/institution, 19 (10.2%) were paid by joint Head Start/other agency funding, and 37 (19.8%) were paid through other arrangements. Including those professionals who were paid in entirety by their agency, Head Start received the services of slightly less than half of the professionals at no cost. This information is consistent with the child-specific data reported by Head Start staff.

Manner of Professionals' Involvement With Head Start

Table 10.12 describes the manner in which the professionals who provided services in each service area became involved with the Head Start programs. For all areas, the professionals were primarily sought out by Head Start. For all areas but health services, the professionals were second most frequently part of the regular Head Start staff, and were least often involved with the child through no coordination with Head Start. Professionals who provided health services were second most frequently involved with the child through no coordination with Head Start and were least often part of the regular Head Start staff.

Non-Head Start Service Providers

The non-Head Start program staff provided information on the professional specialists they utilized in providing services to their handicapped children, whether they coordinated service delivery with other agencies/institutions and, if so, with what agencies they coordinated. These data are program-specific.

TABLE 10.12

Manner of Involvement of Professional Providing Services to Head Start by Service Area

Service Area	Total** % of Row	Part of regular Head Start Staff % of Row	Sought out by Head Start % of Row	No Head Start involvement or coordination % of Row	Other % of Row
Diagnosis	100 (N=278)	21.6 (N=60)	50.4 (N=140)	12.9 (N=36)	15.1 (N=42)
Screening	100 (N=257)	28.8 (N=74)	47.9 (N=123)	6.2 (N=16)	17.1 (N=44)
Therapy	100 (N=119)	29.4 (N=35)	31.1 (N=37)	17.6 (N=21)	21.8 (N=26)
Health (medical) services	100 (N=113)	12.4 (N=14)	34.5 (N=39)	28.3 (N=32)	24.8 (N=28)
Educational services	100 (N=122)	29.5 (N=36)	35.2 (N=43)	22.1 (N=27)	13.1 (N=16)
Parental Counseling/ Training	100 (N=215)	27.9 (N=60)	32.1 (N=69)	21.4 (N=46)	18.6 (N=40)
Teacher/Staff Training	100 (N=185)	* (N=0)	63.8 (N=118)	* (N=0)	36.2 (N=67)

NOTE: Percentages in each row are determined on the basis of the number of service provider cases involved in the relevant area.

Almost all (97.8%) of the non-Head Start programs reported that they utilized professional specialists for service provision to their handicapped children. Further, a wide variety of specialists were reported to be used (see Table 10.13). Psychologists or psychiatrists were used most predominantly (in 78.3% of the programs), followed by speech pathologists or therapists (73.9%), physical therapists (63.0%), and physicians (63.0%). This pattern of most frequently used providers is similar to the Head Start pattern, except that Head Start children were predominantly served by nurses and were infrequently served by physical therapists. The area of service provision within the non-Head Start programs with which the professionals were involved varies by professional type although, across professional type, the predominant involvement areas are the same as for the Head Start children:

- evaluating child progress
- training or consulting with teachers
- working with children at sites other than the classroom

Table 10.14 shows the agencies with which non-Head Start programs coordinated for purposes of providing services to handicapped children in their own program. The two agencies with which non-Head Start programs most frequently coordinated were public school systems (83.3% of the programs) and social services departments (80.9% of the programs), followed by public or State health departments (66.7%) and private practitioners/consultants (61.9%). Programs could indicate any type of agencies with which they coordinated during the program year, and the data include agencies that were used for one-time services such as screening as well as regular services such as physical therapy. The comparative Head Start data, however, only include agencies with which providers of regular services were affiliated; and these predominant agency affiliations were public school systems and private practitioners/consultants, followed by social services departments and public hospitals. The patterns of interagency coordination were similar for Head Start and non-Head Start programs.

TABLE 10.13

Professionals Used for Provision of Services by Non-Head Start Programs

		Involvement Area[2]						
Professional	Total Programs Served[1]	Works With Child at Another Site	Works With Child in the Classroom	Trains/Consults With Teacher	Trains Parents	Evaluates Child's Progress	Observes in Classroom	Other
Physician	63.0 (N=29)	69.0 (N=20)	*	48.3 (N=14)	34.5 (N=10)	51.7 (N=15)	6.9 (N=2)	13.8 (N=4)
Nurse	47.8 (N=22)	63.6 (N=14)	54.5 (N=12)	90.9 (N=20)	68.2 (N=15)	54.5 (N=12)	45.4 (N=10)	4.5 (N=1)
Psychologist/ Psychiatrist	78.3 (N=36)	50.0 (N=18)	36.1 (N=13)	86.1 (N=31)	50.0 (N=18)	94.4 (N=34)	63.9 (N=23)	13.9 (N=5)
Speech Pathologist/ Therapist	73.9 (N=34)	64.7 (N=22)	70.6 (N=24)	76.5 (N=26)	58.8 (N=20)	91.2 (N=31)	73.5 (N=25)	14.7 (N=5)
Social Worker	60.9 (N=28)	39.3 (N=11)	28.6 (N=8)	85.7 (N=24)	85.7 (N=24)	53.6 (N=15)	50.0 (N=14)	25.0 (N=7)
Nutritionist/ Dietician	32.6 (N=15)	40.0 (N=6)	6.7 (N=1)	66.7 (N=10)	60.0 (N=9)	26.7 (N=4)	6.7 (N=1)	26.7 (N=4)
Certified Special Education Teacher	58.7 (N=27)	44.4 (N=12)	92.6 (N=25)	55.6 (N=15)	70.4 (N=19)	92.6 (N=25)	70.4 (N=19)	18.5 (N=5)
Physical Therapist	63.0 (N=29)	65.5 (N=19)	55.2 (N=16)	72.4 (N=21)	62.1 (N=18)	75.9 (N=22)	48.3 (N=14)	17.2 (N=5)
Occupational Therapist	37.0 (N=17)	58.8 (N=10)	58.8 (N=10)	88.2 (N=15)	58.8 (N=10)	88.2 (N=15)	64.7 (N=11)	17.6 (N=3)
Opthamologist/ Optometrist	34.8 (N=16)	93.8 (N=15)	12.5 (N=2)	31.2 (N=5)	31.2 (N=5)	68.8 (N=11)	6.2 (N=1)	12.5 (N=2)
Other Specialist	45.7 (N=21)	66.7 (N=14)	33.3 (N=7)	52.4 (N=11)	52.4 (N=11)	66.7 (N=14)	28.6 (N=6)	14.3 (N=3)

[1] Percentages for this column are based on the total number of programs in the sample (N=46). For example, 29 programs, or 63 percent of the programs, used physicians to provide services to their handicapped children.

[2] Percentages for each row of involvement are based on the total number of programs that used the corresponding type of professional. For example, in 20 programs physicians worked with children at another site, or in 69 percent of the programs that used physicians.

TABLE 10.14

Agencies With Which Non-Head Start Programs Coordinated Services to Handicapped Children

Agency	% of Total[1]
Private Practitioner/Consultant	61.9 (N=26)
Public Hospital	40.5 (N=17)
Public or State Health Department	66.7 (N=28)
Social Services Department	80.9 (N=34)
Public School System	83.3 (N=35)
Easter Seals	42.8 (N=18)
Crippled Children's Association	42.8 (N=18)
Association for Retarded Children	47.6 (N=20)
BEH First Chance Project	9.5 (N=4)
University Affiliated Facilities	33.3 (N=14)
Head Start	40.5 (N=17)
Other	35.7 (N=15)

[1] Percentages are based on a total of 42 programs that coordinated services for their handicapped children with other agencies either occasionally or extensively. Programs could indicate more than one agency.

Summary of Findings

- Almost all of the sample Head Start children (90.3%) received services from professional service providers at some point during the program year. About half of the children were served by nurses and speech pathologists or therapists, and almost half received services from physicians, psychologists/psychiatrists, and social workers. The providers most frequently worked with the child outside of the classroom, evaluated the child's progress, or offered training or consultation to the child's teacher.
- Less than half of the sample children received regular (i.e., weekly) services from specialists. Further, more than half of the sample children were neither regularly served by specialists nor received services from program staff with a degree in special education.
- Of the children who received regular services from specialists, the children's services were predominantly paid by a source other than Head Start or the children's parents--usually the providing agency. Head Start predominantly sought out the services of specialists.
- The group of professionals who provided services to sample children at least once during the program year predominantly provided screening and diagnostic services, and least frequently provided direct intervention services to children.
- Almost all of the non-Head Start programs indicated that professional specialists were used to provide services to their handicapped children. The pattern of predominant types of specialists used and services provided is similar to the pattern for the sample Head Start children. Finally, most of the programs indicated that they coordinated services to handicapped children with other community agencies, usually the public school system and social services departments.

11

PARENT INVOLVEMENT

The active participation of Head Start parents in all aspects of the program is one of the important cornerstones of the Head Start philosophy. For parents of children with special needs, the assistance and guidance which Head Start offers can be of particular significance. To ensure the continuing provision of appropriate services during and after the child's Head Start experience, parents must be aware of and understand the need and importance of these services. Furthermore, to maximize the benefits of developmental experiences provided each child, similar and continuing experiences should be provided in the home as well. Parents are the key to a successful and productive program of services for all children, and especially for those that are handicapped. Therefore, the following questions are investigated in this chapter.

- How involved in the Head Start program were parents of the sample handicapped children? Is parents' extent of involvement related to their child's handicapping condition or severity level?
- In what types of Head Start activities were the parents of sample handicapped children involved?
- What types of training did the parents of the sample handicapped children receive from Head Start?
- How does the typical extent of involvement of handicapped children's parents in non-Head Start programs compare to the involvement of the sample handicapped children's parents in Head Start?

Involvement of Head Start Children's Parents

Degree of Parent Involvement

Table 11.1 shows the level of program involvement of the parents of the sample 269 handicapped children.[1] Responses were fairly evenly distributed among gradations of activity (very active, 27.1%; average involvement, 29.4%; and minor involvement, 30.5%). In only 34 cases (12.6%) were parents reported not to participate at all.

Some caution must be exercised in interpreting these data, however, because in many cases the involvement of parents was contingent upon other, outside circumstances which had little to do with the parents' desire or willingness to participate. Many of the parents worked and were unable to participate in most activities; others were impeded by transportation difficulties or commitments to family or relatives. On the other hand, many of the parents were intimately involved with every aspect of the programs. Some continued to be involved with Head Start after their children had left the program and others returned periodically to keep in touch with the staff and to inform them of their child's progress.

Table 11.2 shows that there is little association between the degree of involvement of the parent and the handicapping condition of their child, with two exceptions. When compared to other parents, those with mentally retarded children were somewhat more active. Thirty seven percent of the parents with mentally retarded children were reported to be very active. At the opposite extreme, 23.8 percent of the parents of blind or visually impaired children did not participate in the program activities at all.

Table 11.3, which compares the degree of parental involvement in program activities with the severity level of their child's handicapping condition, indicates a slight association between those two

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[1] Head Start staff were asked to rate how active the parent was in overall participation in Head Start activities.

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TABLE 11.1

Levels of Parental Involvement in Head Start[1]	
Degree of Involvement	% of Total
Very active	27.1 (N=73)
Average involvement	29.4 (N=79)
Only minor involvement	30.5 (N=82)
Do not participate at all	12.6 (N=34)
No response	0.4 (N=1)
Total	100.0 (N=269)

[1] As reported by program staff. Data are child-specific.

TABLE 11.2

Distribution of Parental Program Involvement by Their Child's Handicapping Condition[1]

Handicapping Condition	Parental Involvement				
	Total ** % of Row	Very Active % of Row	Average % of Row	Minor Involvement % of Row	None % of Row
Visually Impaired and Blind	100 (N=21)	14.3 (N=3)	28.6 (N=6)	33.3 (N=7)	23.8 (N=5)
Hearing Impaired and Deaf	100 (N=23)	30.4 (N=7)	43.5 (N=10)	21.7 (N=5)	4.3 (N=1)
Physically Handicapped	100 (N-37)	29.7 (N=11)	37.8 (N=14)	27.0 (N=10)	5.4 (N=2)
Speech Impaired	100 (N-59)	25.4 (N=15	25.4 (N=15)	35.6 (N=21)	13.6 (N=8)
Health-Development Impaired	100 (N=29)	26.7 (N=8)	36.7 (N=11)	26.7 (N=8)	6.7 (N=2)
Mentally Retarded	100 (N=35)	37.1 (N=13)	14.3 (N=5)	31.4 (N=11)	17.1 (N=6)
Learning Disabled	100 (N=31)	29.0 (N=9)	25.8 (N=8)	29.0 (N=9)	16.1 (N=5)
Emotionally Disturbed	100 (N=33)	21.2 (N=7)	30.3 (N-10	33.3 (N=11)	15.2 (N=5)

[1] Data are child-specific.

TABLE 11.3

Parental Involvement By Severity Level of Child's Handicapping Condition[1]

Severity Level					Degree of Involvement	
	Total** % of Row	Very Active % of Row	Average % of Row	Minor Involvement % of Row	No Involvement % of Row	No Response % of Row
Mild	100 (N=61)	21.3 (N=13)	24.6 (N=15)	34.4 (N=21)	19.7 (N=12)	*
Moderate	100 (N=111)	33.3 (N=37)	31.5 (N=35)	27.0 (N=30)	8.1 (N=9)	*
Severe/Profound	100 (N=80)	22.5 (N=18)	32.5 (N=26)	28.8 (N=23)	15.0 (N=12)	1.3 (N=1)
Not relevant	100 (N=12)	16.7 (N=2)	16.7 (N=2)	58.3 (N=7)	8.3 (N=1)	*
Unknown	100 (N=5)	60.0 (N=3)	20.0 (N=1)	20.0 (N=1)	*	*

[1] Data are child-specific.

factors. While the number of cases in each table cell is small, tentative assumptions may be drawn. That is, parents of children with mild handicapping conditions were less involved than the average for all parents, while parents of moderately handicapped children were more actively involved than average.

Manner of Involvement of Parents

Of all the possible ways in which parents could be involved with Head Start, parents took the most active role in general program activities (see Table 11.4). More than half of the parents (66.5%, or 179 cases) were involved in functions with other Head Start parents. This would include meetings, informal gatherings and social functions. The next major area in which parents were involved was that of making or donating materials for the classroom. Of the 269 sample children, parents of 132 (49.0%) contributed materials for classroom use. Finally, in 108 cases (40.1%) parents provided transportation. In some instances, this merely involved bringing their own child to the center. In others, however, this not only entailed transporting children other than their own, but in some areas it also meant driving many miles several times a day.

Parents did not seem to take as active a part in the program activities more directly related to service delivery and planning. In only 10 cases (3.7%), were parents involved in developing community resource files. Only 9.7 percent of the parents, or 26 cases, participated in outreach or recruitment activities. Parents trained or counseled other parents in only one tenth (27) of the sample cases.

In the development of their children's individual plans of service, parents were involved predominantly through passive activities.1/

1/ Of the sample 269 children, only 187 were reported to have an individual plan of service. Percentages are based on this number rather than on the total sample.

TABLE 11.4

General Program Activities in Which Head Start Parents Were Involved

Activity	% of Children's Parents Involved 1/
Provide transportation	40.1 (N=108)
Train/counsel other parents	10.0 (N=27)
Involvement in outreach/recruitment	9.7 (N=26)
Develop community resource file	3.7 (N=10)
Develop objectives for social service/ parent involvement activities	15.2 (N=41)
Liaison between Head Start and other agency	13.0 (N=35)
Make/donate materials for classroom	49.0 (N=132)
Involvement in functions with other Head Start parents	66.5 (N=179)
Other	14.9 (N=40)

1/ Percentages are based on the sample of 269 handicapped children.

Table 11.5 shows that the single most frequent manner in which parents were involved in the individual plan of services is that of being informed of their child's progress. In slightly more than 80 percent of the cases (152 cases) in which a child had a plan of services, the parent was informed of the child's progress in the classroom. In a little more than half of the cases (99 cases) parents approved the individual plan. While this shows that parents were aware of what Head Start is doing for their child, it also indicates that parents had little input in the experiences to be provided. For example, parents infrequently assisted in the design of the individual plan (15.5%, 29 cases) or in the design of activities (17.1%, 32 cases). A number of parents were, however, involved in teaching their children at home. Slightly more than one third of the 187 children with individual plans (37.5%, 70 cases) received instructions from their parents at home using performance-based and/or experience-based lesson plans developed by Head Start staff.

Parental Training

The training received by parents is an important part of enhancing their understanding of the needs of their children and parenting skills. The acquisition of knowledge and skills in certain areas may also help those parents lacking in self-confidence to take an active and more assertive role in their child's present and future welfare.

Table 11.6 shows the types of training received by Head Start parents of handicapped children and the providers of that training. An examination of the first row gives an indication of the frequency with which certain types of training were provided, regardless of the person responsible for that training. Since parents may receive training in one area by several different providers, the numbers in this row may represent duplicated cases and, therefore, should be interpreted as occasions when training was received rather than the number of parents who received that type of training. The remaining figures in this table, however, include unduplicated cases in which parents received training in a particular training area by one particular training provider.

TABLE 11.5

Parental Involvement in Development of the Individual Plans of Service[1]	
Ways Parents are Involved	**% of Total[2]**
No Involvement	10.2 (N=19)
Parent Teaches Child at Home Using Performance Based Criteria	33.7 (N=63)
Parent Teaches Child at Home Using Experience Based Criteria	37.4 (N=70)
Parent is Kept Informed of Progress in Classroom	81.3 (N=152)
Parent Involved in Classroom Activities	38.0 (N=71)
Parent Assists in Evaluation of Child's Progress	48.1 (N=90)
Parent Designs Activities	17.1 (N=32)
Parent Approves Individual Plan	52.9 (N=99)
Parent Helps Design Individual Plan	15.5 (N=29)
Other	4.3 (N=8)

[1] Includes only those children with an individual plan of services (N=187).

[2] Percentages are based on the sample of children with an individual plan of services. Parents may have been involved in more than one manner.

TABLE 11.6

Training Received by Head Start Parents by Provider of Training[1/]

Provider of Training	Training Types Assessment % of Column	Program Goals and Objectives % of Column	Normal Child Growth and Development % of Column	Identifying Special Needs of Their Child % of Column	Educational Planning % of Column	Availability of Other Community Resources % of Column	Legal Rights Related to Their Child % of Column	Genetic Counseling % of Column	Emergency First Aid % of Column	Information Concerning Their Child's Specific Handicap % of Column	Other % of Column
Total	N=70	N=171	N=118	N=155	N=85	N=140	N=72	N=20	N=54	N=245	N=25
Local Head Start Staff	19.0 (N=51)	49.4 (N=133)	30.1 (N=81)	37.2 (N=100)	26.4 (N=71)	44.6 (N=120)	18.6 (N=50)	0.7 (N=2)	13.8 (N=37)	46.1 (N=124)	4.8 (N=13)
Other Professionals	7.1 (N=19)	11.2 (N=30)	11.9 (N=32)	17.1 (N=46)	4.1 (N=11)	6.7 (N=18)	6.7 (N=18)	5.2 (N=14)	4.5 (N=12)	37.5 (N=101)	3.7 (N=10)
Regional/State Head Start Staff	*	1.5 (N=4)	0.7 (N=2)	0.7 (N=2)	0.4 (N=1)	0.4 (N=1)	*	*	0.7 (N=2)	1.1 (N=3)	0.4 (N=1)
Others	*	1.5 (N=4)	1.1 (N=3)	2.6 (N=7)	0.7 (N=2	0.4 (N=1)	1.5 (N=4)	1.5 (N+4)	1.1 (N=3)	6.3 (N=17)	0.4 (N=1)

[1/] Data are child-specific.

Note: Percentages were derived from total number of children (269). Since parents may receive the same type of training from different providers the total N may represent duplicated cases.

Most of the training parents received concentrated upon the nature and implications of their child's handicapping condition. On 245 occasions parents received training concerning their child's specific handicap, and training in the identification of the special needs of each child was received by parents on 155 occasions. Program goals and objectives were also a frequent training topic, occurring a total of 171 times. Training in educational planning (N=85) and in assessment (N=70) occurred with low frequencies.

Local Head Start staff provided most of the training received by children's parents. They were the primary providers of information relating to the handicapping condition of the sample children. Parents of 124 children (46.1% of the total sample) received information concerning their child's specific handicap from local Head Start staff. The major contribution of training provided by other professionals was in this area also; 101 parents (37.5%) received training relative to their child's condition by other professionals. Outside professionals were seldom used to provide parent training in any of the other training areas considered.

Non-Head Start Program Parent Involvement

There seems to be little difference between Head Start and non-Head Start programs in the involvement of parents in program activities. Similar to Head Start, most non-Head Start programs included parents on an advisory board,[1/] offered training in a variety of areas, and involved parents in the same types of general program activities.

Table 11.7 shows the ways in which non-Head Start parents participated in program activities.[2/] As with the Head Start parents, non-Head Start programs indicated that parents were primarily involved

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[1/] Thirty-seven of the 46 non-Head Start programs (80.4%) indicated that there was parental representation on their advisory boards.

[2/] Across areas of potential involvement, the extent of parental involvement did not differ significantly depending upon whether the program had a mainstream setting.

TABLE 11.7

General Program Activities in Which Parents of Handicapped Children in Non-Head Start Programs Were Typically Involved

Involvement	% of Programs[1]
Provide transportation	63.0 (N=29)
Train/counsel other parents	37.0 (N=17)
Involvement in outreach/recruitment	50.0 (N=23)
Develop community resource file	15.2 (N=7)
Develop objectives for social service/ parent involvement activities	39.1 (N=18)
Make/donate materials for classroom	63.0 (N=29)
Involved in functions with other parents	47.8 (N=22)
Other	56.5 (N=26)

[1] Percentages are based on the total of 46 non-Head Start programs.

through making or donating classroom materials, providing transportation, or attending functions with other parents.

Training received by parents in non-Head Start programs (see Table 11.8) was basically similar to that which Head Start parents received. Information concerning a child's specific problems and special needs was the predominant type of training in both kinds of programs.

Summary of Findings

The following is a brief summary of the major findings concerning parent involvement in Head Start and non-Head Start programs:

- The general level of parent involvement of handicapped children in Head Start programs was fairly evenly distributed among very active, average, and minor involvement. Few parents did not participate at all.
- There was little association between parent involvement and the handicapping condition and severity level of the child. Parents of mentally retarded children showed a somewhat higher degree of participation, while parents of blind and visually impaired children tended to have a lower degree of involvement. Parents of children who were mildly impaired tended to participate less; those with moderately disabled children were somewhat more active; parents with children of severe or profound handicapping conditions, as well as the blind, deaf and emotionally disturbed, had average to minor involvement.
- While Head Start parents were involved in a variety of activities, these were primarily passive in nature and did not seem to involve parents in active leadership or planning roles.
- Training provided to Head Start parents was concentrated in areas concerning the handicapping conditions of their particular children. Most parent training was provided by Head Start staff.
- There seems to be little difference between Head Start and non-Head Start programs in the ways in which parents were involved in program activities.

TABLE 11.8

Training Received by Parents in Non-Head Start Programs

Training Types	% of Programs[1]
Program goals and objectives	65.2 (N=30)
Normal child growth and development	45.7 (N=21)
Identifying special needs of their children	82.6 (N=38)
Educational planning	65.2 (N=30)
Availability of other community resources	84.8 (N=39)
Legal rights related to their child	58.7 (N=27)
Genetic counseling	21.7 (N=10)
Information concerning their child's specific handicap	89.1 (N=41)
Home management of child/activities for parents to do with child	91.3 (N=42)
Other	45.7 (N=21)

[1] Percentages are based on a total of 46 non-Head Start programs.

PART III

STUDY CONCLUSIONS AND RECOMMENDATIONS

12

CONCLUSIONS AND RECOMMENDATIONS

There is no question that Head Start programs are exerting considerable effort to comply with the Congressional mandate to seek out and serve handicapped children. Over the course of the ten week Phase I data collection effort, field staff had the opportunity to visit several Head Start facilities that offered exceptional services to their handicapped enrollees in each of the major Head Start program areas (education, health, social services, and parent involvement). In many instances children were encountered who, if not for Head Start, would have remained isolated from their non-handicapped peers and would not have received the assistance they required. Noteworthy examples of Head Start efforts to serve the handicapped included one or more programs that:

- made creative use of "reverse" mainstreaming to provide severely handicapped children the opportunity to interact with their non-handicapped peers in a setting that afforded appropriate supportive services;
- provided instructional services to parents of handicapped children who themselves were handicapped;
- provided technical assistance to other programs involved with handicapped children;
- utilized creative techniques which permitted handicapped children to participate in group lessons/activities with their non-handicapped peers and at the same time receive services according to their individual needs;

- established well-equipped instructional centers specifically established for handicapped children;
- closely cooperated with public and private categorical preschool for the handicapped to allow children in these other settings to interact with non-handicapped peers;
- augmented their capacity to provide services to the handicapped by securing in-kind assistance for highly qualified therapists and special educators.

In brief, many Head Start programs are continuing to reach out and serve those children that are too often ignored and forgotten by their respective communities. Furthermore, these children are being served in a comprehensive child development framework that emphasizes mainstreaming and interagency service delivery that is truly unique among programs visited.

The Evaluator's Perspective

The major purpose of a program evaluation is not, however, simply to applaud efforts that successfully meet a program's objectives. Rather, an evaluation weighs a program's performance against its stated mission and, as a consequence, almost always focuses upon those aspects of a program that are not as effective as they could be. Based on observed shortcomings, recommendations are then formulated to guide constructive changes and/or innovations which will increase a program's capability to fulfill its particular mission. From the perspective of the evaluator, then, the glass of water is perceived to be partially empty rather than almost full.

There is also another evaluation emphasis throughout this specific study which should be explicated. Head Start emphasizes services to handicapped children within a comprehensive developmental framework. An educational program is but a part of the Head Start service model. Health services, parent/family involvement, social services, and nutritional services are just as important in child development as educational services. For the most part, these other service areas were only superficially considered in this study. Instead, major emphasis was placed upon educational services, principally because of new legislation (Public Law 94-142) which will directly and indirectly affect educational services to all handicapped children regardless of their program placement. Additionally, this emphasis was selected because it is the one service area which is common to Head Start as well as non-Head Start programs. Therefore, for comparative purposes it was the only appropriate service area to address in detail.

Areas for ACYF Action

With the above points in mind, the data from this study have identified several areas in which the services Head Start provides to handicapped children can be improved. There are four major areas in which ACYF can take positive action to effect these improvements. These four areas are as follows:

- diagnostic services provided to handicapped children
- program services provided to handicapped children
- program resources and facilities
- program outreach and recruitment efforts

Recommendations pertaining to each of these issues are presented below.

Diagnostic Services Provided to Handicapped Children

The designation of an individual as "handicapped" is not a matter to be taken lightly. To be diagnosed as handicapped may result in stigmatization and the effects of this stigmatization can often be more harmful for the development of an individual than his/her disability. The "handicap" designation creates a set of personal and public expectations that can prohibit the individual from reaching his/her full potential as a functioning member of the community.

Although it is the conclusion of this study that Head Start has made significant gains in improving its diagnostic services to handicapped children, there still are shortcomings to be addressed. There were instances in which field staff had reservations about the appropriateness of certain diagnoses. In other instances, Head Start teachers were unaware that children in their classes were identified as handicapped. Ear infections were reported as hearing impairments, behavior management problems as emotional disturbance, bilingualism as speech impairment, and unusual body structures as health impairments.

We do not mean to impugn the validity of all reported handicaps in Head Start because the majority of children investigated had clearly recognizable disabilities. However, beyond a doubt there is misuse and abuse of the diagnostic process and it is not an occasional problem. This is a problem which not only impacts Head Start children and their families, but it is a problem which is also responsible for the disparagement and criticism of the Head Start handicapped effort that field staff sometimes encountered among non-Head Start programs.

Based on the findings of the Phase I study and the general observations of our field staff, the misuse and abuse of the diagnostic process in Head Start has been identified as largely a function of two factors: 1) failure of some programs to implement existing Head Start standards and criteria in the conduct of the diagnostic process, and 2) pressures to meet the Congressional mandate to ensure that no less than 10 percent of Head Start enrollment opportunities be made available to handicapped children.

SPECIFIC ISSUE:

STUDY DATA REVEALED THAT IN SEVERAL INSTANCES CHILDREN WERE NOT DIAGNOSED AS HANDICAPPED IN ACCORDANCE WITH EXISTING HEAD START STANDARDS AND CRITERIA.

As detailed in Chapter 7, a series of interrelated findings indicated that the proper sequence of diagnostic activities did not occur for a number of handicapped children. Approximately 10 percent of the sample children were identified as handicapped without diagnostic confirmation of the existence of the handicap.[1] The rate of non-confirmation was particularly high for children labeled emotionally disturbed, learning disabled, and health or developmentally impaired (approximately 28%, 26%, and 20%, respectively). Further, among those children labeled as emotionally disturbed and learning disabled who did receive diagnostic confirmations, many received confirmations in developmental areas unrelated to the handicaps in question.

RECOMMENDATION:

ACYF SHOULD TAKE IMMEDIATE STEPS TO ENSURE THAT NO CHILD IS REPORTED AS HANDICAPPED WITHOUT DIAGNOSTIC CONFIRMATION BY APPROPRIATELY CREDENTIALLED PROFESSIONALS.

RECOMMENDATION:

DIAGNOSTIC CRITERIA SHOULD BE MADE MORE STRINGENT IN ALL HANDICAPPING AREAS, PARTICULARLY IN THE AREAS OF LEARNING DISABILITIES AND EMOTIONAL DISTURBANCE. ACYF SHOULD ACCEPT THE LEAD IN ESTABLISHING INTERAGENCY EFFORTS TO DEVELOP DIAGNOSTIC CRITERIA WHICH MIGHT SERVE AS A REFERENCE FOR ALL AGENCIES PROVIDING DIAGNOSTIC SERVICES TO HANDICAPPED CHILDREN.

Concerning both of these recommendations, ACYF needs to take a series of steps to upgrade the diagnostic services provided to handicapped children in Head Start, particularly for children identified as emotionally disturbed, learning disabled, and health or developmentally impaired. We suggest the following actions:

- Develop and disseminate well-defined and detailed guidelines for delivery of diagnostic services which clearly delineate the diagnostic model in full.
- Establish more stringent diagnostic criteria for children labeled as learning disabled or emotionally disturbed.

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[1] "Without diagnostic confirmation" means that program staff reported that, to their knowledge, the presence of a handicapping condition had not been verified by a diagnostician. Diagnostic files reviewed did not support handicap diagnosis in at least 15 percent of the cases.

- Monitor more closely the diagnostic services that Head Start programs deliver to their handicapped enrollees.
- Provide more extensive training and technical assistance in appropriate diagnostic confirmation procedures to Head Start program staff, and encourage local programs to offer extensive inservice training in this area to their staff.

SPECIFIC ISSUE:

PROGRAM STAFF ADMITTED THAT MISUSE OF THE DIAGNOSTIC PROCESS WAS, IN PART, A FUNCTION OF PRESSURES TO COMPLY WITH THE CONGRESSIONAL MANDATE TO PROVIDE NOT LESS THAN 10 PERCENT OF HEAD START ENROLLMENT OPPORTUNITIES TO HANDICAPPED CHILDREN.

Although well-intentioned, the requirement of the Head Start, Economic Opportunity, and Community Partnership Act of 1974 that not less than ten percent of the total number of enrollments in Head Start programs in each State be available for handicapped children has created tremendous pressure on Head Start to identify children who have extremely marginal and transitory disabilities as being handicapped.

Also, because Account 26 funds are made available on the basis of whether a program fulfills this mandate, the 10 percent requirement fosters tremendous financial incentive to inappropriately identify children as handicapped. In fact, one Head Start director openly admitted to field staff that funding often dictates labeling of children. This, of course, is not a problem specific to Head Start. It is a persistent problem throughout special education programs. Nevertheless, it is a problem which should not be tolerated under any circumstances.

RECOMMENDATION:

ACYF SHOULD DEVELOP GUIDELINES THAT WOULD OUTLINE CREATIVE, CHILD-CENTERED ENROLLMENT STRATEGIES THAT WOULD ALLOW HEAD START PROGRAMS TO FULFILL THEIR MANDATE TO SERVE HANDICAPPED. FOR EXAMPLE, COOPERATIVE ARRANGEMENTS WITH OTHER CATEGORICAL PRESCHOOL PROGRAMS THAT WOULD ALLOW CHILDREN MAINSTREAMING EXPERIENCES MAY BE CONSIDERED.

ACYF should encourage Head Start programs to pursue approaches to mainstreaming that would lessen the pressure among various agencies to compete for children from a finite handicapped preschool population. One program's "loss" should not automatically imply another's "gain". For example, field staff encountered at least two programs in which children received a mainstreaming experience in Head Start for a portion of the program week and were then transferred to a public school setting for in-depth therapeutic and educational services. Both Head Start and the public schools considered these children as enrollees of their particular programs thereby relieving funding pressures. At the same time, however, the children were provided with first-rate services.

RECOMMENDATION:

ACYF SHOULD BRING TO THE ATTENTION OF THE APPROPRIATE CONGRESSIONAL COMMITTEE THE NEGATIVE CONSEQUENCES OF THE LEGISLATIVE MANDATE. ACYF SHOULD RECOMMEND TO CONGRESS THAT THE 10 PERCENT QUOTA SHOULD BE CONSIDERED A GUIDELINE RATHER THAN A REQUIREMENT AND THAT ACCOUNT 26 FUNDS SHOULD BE MADE AVAILABLE WHETHER OR NOT A PROGRAM MEETS THIS GUIDELINE.

We further suggest that the 10 percent requirement be modified slightly so that programs justifiably unable to meet the mandate are not penalized through loss of Account 26 funding. Rather, we believe programs should continue to receive funds earmarked for handicapped services irrespective of the proportion of handicapped children enrolled.

However, we realize that weakening the 10 percent mandate could possibly result in a certain amount of backsliding among Head Start programs with respect to their handicapped efforts. Therefore, we recommend that any program unable to meet the mandate should be required to fully document the reasons for the short fall and detail the outreach efforts undertaken. Before this report is accepted, Regional ACYF personnel should review the program's outreach and recruitment practices to ensure that a reasonable effort has been made to locate potential handicapped enrollees. If a review of a program's outreach effort indicates that failure to meet the 10 percent guideline is a function of inadequate outreach activities, then we recommend that a portion of the handicapped funds provided to that program be specifically earmarked for the development of more intensive activities in this area.

We further recommend that the level of funding for handicapped services on a per pupil basis be increased substantially for programs able to meet the 10 percent guideline and where the nature of children's handicaps clearly requires extraordinary expenditures for more highly trained staff and/or special equipment. This would provide a financial incentive for developing strong handicapped outreach efforts that is less likely to result in mislabeling than in the present system of allocation of handicapped funds.

RECOMMENDATION:

ACYF SHOULD CONSIDER A LONGITUDINAL STUDY OF HANDICAPPED CHILDREN ENROLLED IN HEAD START THAT WOULD HAVE AS ONE OF ITS OBJECTIVES AN ASSESSMENT OF THE VALIDITY OF DIAGNOSTIC RESULTS HEAD START USED TO ASSIGN HANDICAPPED LABELS. IDEALLY, SUCH AN ASSESSMENT SHOULD BE CONDUCTED AFTER CHILDREN ENTER THEIR THIRD YEAR OF PUBLIC SCHOOLING WHEN THE PERMANENCY OF DISABILITIES BECOMES MORE APPARENT.

Finally, we strongly suggest a nationwide diagnostic validation study in which independent diagnostic teams reconfirm both the nature and severity of disabilities assigned to handicapped children in Head Start. Further, this study should also be used to reconsider current ACYF diagnostic guidelines. In addition to providing ACYF with conclusive data on the extent of this problem, the announcement of such a study should also make programs far more cautious in their diagnostic practices.

Program Services Provided to Handicapped Children

As initially conceptualized, Project Head Start was intended to facilitate the assimilation of children into the public school system who, by reason of economic disadvantage, might otherwise have not had the necessary social experiences to successfully adjust to the public school milieu. In addition to so-called compensatory educational experiences, the early promoters of Head Start recognized that a comprehensive set of services was required involving health and dental care, family assistance, and parental counseling. This comprehensive service model recognized that the development of social competence, defined as "the child's everyday effectiveness in dealing with his/her environment and responsibilities in school and later life," was contingent upon many factors. Even today, there are few preschool programs that seek to administer so completely to the needs of children and their families.

However, the development of social competency in children who suffer from physical and/or mental disadvantage often requires an approach quite different from that required in the case of children who suffer economic disadvantage. In the latter situation a typical objective in the pursuit of social competency might be to develop a sound understanding of oral hygiene through activities designed to show the importance of brushing teeth and avoiding sweets. In the case of handicapped children, a similar objective may first require careful and painstaking instruction just to have the child become capable of manipulating a toothbrush.

The level of instructional sophistication and programming required in meeting the oral hygiene objective with the handicapped child is far greater than that required to meet this same objective with his/her non-handicapped peers. With the handicapped child, imparting social skills requires careful assessment of the child's level of functioning, development of individualized instructional strategies for accomplishing discrete tasks related to the skill in question, repetition of instruction until the objective has been accomplished and the utilization of specialized professionals to assist in those aspects of a service plan that are beyond the capability of the typical educator. The level of effort is much greater than that required for the non-handicapped child. In brief, whereas compensatory education has characterized Head Start's efforts with non-handicapped children, primary educational intervention and associated services are necessary to effectively meet the needs of handicapped children.

The data in the previous chapters have indicated, however, that in some respects, many Head Start programs are not prepared to deliver the kind of quality service that handicapped children demand. For example, nearly all the sample children were mainstreamed, but 39 percent were mainstreamed without supportive services. There were several children (10 of 71) with severe handicaps who were considered mainstreamed but some question exists as to whether they were actually benefiting from being mainstreamed because they remained essentially isolated from their non-handicapped peers.

Furthermore, nearly 40 percent of the children investigated were not provided instructional programs guided by a formal (written) individualized plan of services. Among those children who did have plans, many relied heavily on non-directed learning experiences to develop social, cognitive, and motor skills.

Other data indicated that, compared to non-Head Start programs, Head Start staff were far less prepared academically to serve handicapped children and it was not apparent whether this deficit was being adequately addressed through inservice training.

Finally, and perhaps most critically, functional assessments, so necessary to the development of appropriate plans of services, were not completed for many of the sample children until the program year was well under way.

Based on these findings, we feel that ACYF needs to consider immediate steps to upgrade the quality of services to Head Start programs to provide to handicapped children. To summarize, the basic problems are as follows:

- Unacceptable delays between the time children are enrolled in Head Start and the time functional assessments are completed.
- Absence of individual plans of services and/or plans of services that provided for ineffective or inappropriate strategies to promote the development of handicapped children.
- The pursuit of a mainstreaming experience as an end rather than as a means.
- Lack of adequate staff preparation and inservice training to effectively deal with the special needs of the handicapped and, other than for diagnostic confirmations, an underutilization of outside professionals to assist and support Head Start staff in the provision of therapeutic and instructional services to the handicapped.

Recommendations addressing each of these problem areas are outlined below.

SPECIFIC ISSUE:

FUNCTIONAL ASSESSMENTS NECESSARY FOR THE DEVELOPMENT OF INDIVIDUALIZED PLANS OF SERVICES WERE FREQUENTLY NOT COMPLETED UNTIL LATE IN THE HEAD START PROGRAM YEAR.

Data in Chapter 7 indicated that for a variety of reasons, many of the sample children did not receive functional assessments related to their specific handicaps until late in the program year. Without such assessments, it is difficult to develop individualized plans of services to meet the needs of handicapped children. Consequently, ACYF must take steps to ensure that assessments occur as soon in the program year as possible so that handicapped Head Start enrolless might obtain the maximum benefits of this program experience.

RECOMMENDATION:

IN ORDER TO DELIVER SERVICES TO HANDICAPPED CHILDREN IN A TIMELY MANNER, SCREENING ACTIVITIES SHOULD OCCUR PRIOR TO PROGRAM ENTRY INSOFAR AS POSSIBLE, OR AT LEAST IMMEDIATELY FOLLOWING PROGRAM ENTRY. TO FACILITATE THIS PROCESS, ACYF SHOULD MAKE FUNDS AVAILABLE FOR SCREENING ACTIVITIES DURING THE CURRENT PROGRAM YEAR FOR THE UP-COMING YEAR'S RECRUITMENT EFFORTS.

Screening is the first step in a series of events (including diagnosis and functional assessment) intended to culminate in the development of an individualized program of activities for handicapped children. Screening is only important vis-a-vis diagnosis, since its purpose is to provide a more efficient diagnostic process by quickly targeting a subgroup of children "at risk" of having problems. Children, however, cannot legitimately be determined to be handicapped solely on the basis of screening results. For the handicapped children in this study, screening did not occur sufficiently early in the program year to permit timely service delivery, as the following summary of results indicates.

The Head Start Program Performance Guidelines recommend that each child should be completely screened within 90 days of program entry. Over one-third of the sample children were not screened within this period. Furthermore, even if a child is screened within 90 days of program entry, a great deal of additional time may elapse while his/her confirmation of handicap and functional assessment are conducted and recommendations are developed. Well over half of the program year may elapse before a child receives services based upon this series of increasingly refined evaluations, even if the evaluations were conducted in accordance with the Performance Guidelines.

Screening should be conducted as early as possible for each child so that timely services can be delivered to the children determined to be handicapped. We believe that Head Start programs could easily conduct screening services in conjunction with recruitment efforts that occur prior to the beginning of the program year.

To do this, though, we believe it necessary that ACYF make available Program 26 funds specifically earmarked for preenrollment screening, and these funds should be made available in the program year prior to the one for which potential enrollees are being screened.

Screening during the course of the program year should be reserved for those children who are not recruited until the program has started. Screening must occur at an earlier time than it currently does if Head Start is to effectively provide appropriate services to handicapped children.

RECOMMENDATION:

THE ORDER AND RELATIVE PRIORITY OF THE COMPONENTS OF THE DIAGNOSTIC PROCESS SHOULD BE CHANGED. SPECIFICALLY, FUNCTIONAL ASSESSMENTS SHOULD OCCUR AS EARLY IN THE PROGRAM AS POSSIBLE. CONFIRMATION OF HANDICAPS MAY, IF NECESSARY, BE CONDUCTED AT A LATER DATE, SINCE THE CONFIRMATION COMPONENT OF THE DIAGNOSTIC PROCESS, BY ITSELF, IS NOT AS CRITICAL TO THE DEVELOPMENT OF SERVICE PLANS. APPROPRIATELY CREDENTIALLED PROFESSIONALS SHOULD BE INVOLVED IN FUNCTIONAL ASSESSMENT PROCEDURES.

In order to further facilitate the delivery of services to children in Head Start, there is no reason why each child should not receive a functional assessment immediately upon program entry. Techniques exist for such assessments that would allow Head Start staff to perform these assessments relatively independently of the rest of the diagnostic process, particularly for class based services. (However, to the extent possible, appropriately credentialled professionals should be involved in assessment procedures and/or the interpretation of assessment results). Based on these early assessments, plans of services could be established and implemented without waiting for the conclusion of the process Head Start staff must undertake to establish a confirmed diagnosis of a handicapping condition.

SPECIFIC ISSUE:

MANY OF THE HEAD START CHILDREN INCLUDED IN THIS STUDY DID NOT HAVE INDIVIDUAL PLANS OF SERVICES OR HAD PLANS OF SERVICES THAT PROVIDED FOR INCOMPLETE STRATEGIES TO PROMOTE THE DEVELOPMENT OF HANDICAPPED CHILDREN.

It is clear that the requirements to develop individualized plans for handicapped children, and the requirement to document these plans in a written individual plan of services, were not fully implemented by many of the Head Start programs in the sample. For example, although the staff indicated that almost 70 percent of the children had individual plans of services, written plans were located in the children's files for only half of the sample. Many of the existing written plans did not address the full range of activities required by the Performance Guidelines. Many plans contained very minimal amounts of information and, in the opinion of field staff, were an insufficient basis for service delivery. Field staff also reported that the Head Start staff with whom they spoke did not always understand the concept of individualized planning or the need to develop a detailed, comprehensive plan of services for each handicapped child.

Monitoring activities were reported for almost all of the children and service plans of almost all of the children who had them were reportedly modified on the basis of monitoring results. However, since structured assessments were infrequently used for monitoring purposes and since there seemed to be little relationship between monitoring and service plans, we question the usefulness of the monitoring activities that were reported. The data provided did not permit a direct assessment of this issue.

RECOMMENDATION:

ACYF MUST TAKE STEPS TO ENSURE THAT HEAD START STAFF DEVELOP COMPREHENSIVE INDIVIDUALIZED SERVICE PLANS FOR THEIR ENROLLEES. ACYF MUST DELINEATE AS CLEARLY AS POSSIBLE THE PROCESS OF INDIVIDUALIZED PLANNING, THE AREAS THESE PLANS MUST ADDRESS, AND THE MODIFICATION OF PLANS AS A FUNCTION OF ONGOING ASSESSMENT.

RECOMMENDATION:

THE EDUCATIONAL SERVICES PLAN FOR HANDICAPPED CHILDREN SHOULD MEET THE REQUIREMENTS OF INDIVIDUAL EDUCATIONAL PLANS (IEP) AS OUTLINED IN PUBLIC LAW 94-142. THIS WOULD GREATLY FACILITATE SERVICE CONTINUITY BETWEEN HEAD START AND THE PUBLIC SCHOOLS.

RECOMMENDATION:

GREATER EMPHASIS SHOULD BE PLACED ON EDUCATIONAL SERVICE PLANS THAT REQUIRE OBJECTIVE-BASED INSTRUCTIONAL STRATEGIES.

Relative to this last recommendation, we believe that if a primary goal of Head Start is to develop social competency in handicapped children, Head Start programs must orient themselves toward a service model that emphasizes educational intervention. By educational intervention, we mean programs of instruction in the areas of cognitive development, fine and gross motor development, and social skills that are imparted through directed instructional strategies. As indicated in an earlier chapter, many Head Start programs utilize non-directed instructional methods. Such methods are quite satisfactory for non-handicapped enrollees who can be expected to gain much from such instructional techniques. However, handicapped children may need, in addition, more directed instructional services to learn basic skills that non-handicapped children may learn incidentally.

SPECIFIC ISSUE:

SEVERAL CHILDREN INCLUDED IN THIS STUDY WERE FOUND TO BE MAINSTREAMED ONLY IN THE BROADEST SENSE OF THE TERM; THAT IS, SOME HANDICAPPED CHILDREN WERE SERVED IN THE COMPANY OF NON-HANDICAPPED PEERS BUT REMAINED SOCIALLY ISOLATED.

One of the strengths of Head Start's approach to serving handicapped children is the strong emphasis on mainstreaming. As the data in this report have indicated, almost all the children investigated were served in a mainstream context. There is the concern, though, that mainstreaming is often pursued as a goal in itself rather than a means to an end. Mainstreaming must be evaluated for each handicapped child as if it were one of many possible components of an individual plan of services. For most children, mainstreaming should contribute positively toward the development of self-respect, self-confidence and social competency. For other children, though, mainstreaming applied indiscriminately may contribute nothing. Even worse, it may detract from a more intensive program of services that the child's disability requires.

We strongly believe that if Head Start is to continue to serve handicapped children, particularly those with severe disabilities, then local programs should be allowed to develop an individual plan of services most appropriate for a given child even if that plan requires only limited contact with non-handicapped peers. The goal should be to provide services in the least possible restrictive placement commensurate with the child's functional abilities and instructional/therapeutic needs.

RECOMMENDATION:

ACYF SHOULD ESTABLISH TECHNICAL ASSISTANCE EFFORTS TO BETTER PREPARE HEAD START PROGRAM STAFF TO IMPLEMENT VARIOUS MAINSTREAMING OPTIONS THAT COULD BE IMPLEMENTED THAT WOULD BEST MEET THE INDIVIDUAL NEEDS AND ABILITIES OF THE CHILD. IT IS IMPORTANT THAT MAINSTREAMING BE A MEANS TO AN END RATHER THAN AN END IN ITSELF.

SPECIFIC ISSUE:

HEAD START STAFF APPEAR TO LACK FORMAL PREPARATION TO DEAL WITH THE SPECIAL NEEDS OF THE HANDICAPPED AND THIS LACK OF FORMAL PREPARATION IS NOT ADEQUATELY COMPENSATED THROUGH THE UTILIZATION OF OUTSIDE PROFESSIONALS.

Handicapped children in Head Start are not often served by classroom staff with relevant academic training. Even though half of the study children had teachers with at least a college degree, less than half of this group of teachers had a degree in either early childhood education or special education. Only 20 percent of the children had teachers with extensive preparation (i.e., academic degrees) in early childhood or special education. Whereas this situation may well be satisfactory for non-handicapped children, it is, in the absence of resource assistance, far more difficult to justify for children with moderate to severe handicaps.

The overall educational level of classroom teachers and the proportion of teachers with degrees in special education was much higher for the non-Head Start programs, including programs that provided a mainstream setting. If one assumes that teachers' training has an impact on the growth and development of children in their classes, it appears that most of the handicapped children in Head Start had teachers who were not well prepared to meet their special needs. It should be stressed that we are not suggesting that a degree in special education should be required to teach handicapped children in a Head Start program. To the contrary we recognize and support the concept that highly effective services can be rendered by paraprofessionals, provided however, that they receive the prerequisite training. This training was not in evidence for many of the Head Start personnel encountered in this study. Only 10 percent of the children's staff received training in any one area related to handicapped services for 15 hours or more, and consequently this training must be considered only marginal.

Lack of specialized training of the teaching staff could be compensated for if children receive regular services from specialists who are trained to meet their unique needs. Although most all of the children in the study sample received services from professionals at least once during the program year, including screening and/or diagnosis, only 40 percent of the children received intervention or therapeutic services from professionals on a regular and frequent basis (i.e., at least weekly). Furthermore, over half of the sample children (56%) did not receive any one-to-one services other than screening or diagnosis from a specialist (i.e., a staff member with a degree in special education or an external specialist) during the program year.

RECOMMENDATION:

ACYF SHOULD EXPAND THE EXISTING CHILD DEVELOPMENT ASSOCIATE (CDA) PROGRAM TO INCLUDE THE CREDENTIALING OF STAFF IN SPECIAL EDUCATION SERVICES.

RECOMMENDATION:

ACYF SHOULD PROVIDE FUNDS THROUGH ACCOUNT 26 TO PERMIT HEAD START STAFF SPECIFICALLY TO SECURE THE SERVICES OF OUTSIDE PROFESSIONALS FOR PURPOSES OF PROVIDING DIRECT AND INTENSIVE SERVICES TO HANDICAPPED CHILDREN ENROLLED IN HEAD START.

Resources and Facilities

SPECIFIC ISSUE:

HEAD START CLASSROOMS ARE OFTEN NOT EQUIPPED TO MEET THE NEEDS OF SEVERELY HANDICAPPED CHILDREN.

Another area in which we believe ACYF could improve the Head Start handicapped effort concerns the resources and facilities available to Head Start programs. Data in Chapter 3 clearly indicated that many Head Start classrooms are not equipped to serve certain handicapped children, particularly those that are severely handicapped and/or are physically handicapped. This lack of equipment involves not only aspects of the physical plant of Head Start classrooms (e.g., plumbing and sanitary facilities) but also special instructional materials to support educational and therapeutic programs.

RECOMMENDATIONS:

ACYF SHOULD MORE AGGRESSIVELY PUBLICIZE THE AVAILABILITY OF ACCOUNT 26 FUNDS FOR UPGRADING AND MODIFYING PHYSICAL FACILITIES AND SPECIAL EQUIPMENT NECESSARY TO PROVIDE APPROPRIATE SERVICES TO THE SEVERELY HANDICAPPED.

RECOMMENDATION:

ACYF SHOULD PROVIDE HEAD START PROGRAMS WITH TECHNICAL ASSISTANCE TO IDENTIFY ARCHITECTUAL BARRIERS TO SERVING THE HANDICAPPED AND HOW TO USE AVAILABLE FUNDS TO UPGRADE CLASSROOM FACILITIES.

RECOMMENDATION:

ACYF SHOULD DEVELOP EQUIPMENT AND MATERIALS GUIDELINES FOR HEAD START PROGRAMS SO THAT PROGRAM STAFF CAN BETTER EVALUATE THEIR SPECIFIC EQUIPMENT NEEDS. THESE GUIDELINES SHOULD, WHEN APPROPRIATE, BE DEVELOPED FOR EACH OF THE BASIC HANDICAPPING CONDITIONS SERVED BY HEAD START.

During the course of field work activities, Head Start staff personnel often asked field staff for assistance in such areas as the selection of screening instruments, acquisition of staff training materials to support their handicapped services, and the interpretation of various Head Start program standards and regulations pertaining to handicapped children. Also, in establishing the Phase I sample, it was clear to project staff that much confusion exists concerning the diagnostic criteria Head Start programs are supposed to follow in the labeling of children for reporting purposes. In short, the level of technical assistance ACYF has provided to Head Start grantees must be upgraded.

SPECIFIC ISSUE:

HEAD START PERSONNEL, IN SOME PROGRAMS, ARE UNAWARE OR UNSURE OF METHODS AVAILABLE FOR WORKING WITH HANDICAPPED CHILDREN. FURTHER, PROGRAM STAFF ARE UNSURE ABOUT HEAD START PROGRAM REGULATIONS AND STANDARDS THAT APPLY TO EFFORTS TO SERVE HANDICAPPED CHILDREN.

RECOMMENDATION:

EFFORTS SHOULD BE MADE TO PROMOTE THE UTILIZATION OF RESOURCE ACCESS PROJECTS (RAPs) TO STRENGTHEN THE QUALITY OF SERVICES HEAD START PROGRAMS CAN PROVIDE HANDICAPPED CHILDREN. SPECIFICALLY, RAPs SHOULD BE PROVIDED WITH BUDGETS TO CONDUCT TRAINING AND TECHNICAL ASSISTANCE ACTIVITIES THAT HERETOFORE RAPs WERE FORCED TO ARRANGE FROM OTHER SOURCES. IF POSSIBLE, RAPs SHOULD BE ESTABLISHED AT THE STATE LEVEL.

Throughout the data collection effort only occasional references were made to the RAPs. Because many of the requests for assistance we received clearly fell within the scope of activities RAPs were established to perform, we believe considerable effort must be made to promote awareness among Head Start programs concerning the services RAPs can provide. Furthermore, RAP personnel, preferably in coordination with other training facilities, should endeavor to implement an on-going needs assessment program and quickly follow up at the individual program level any reported or perceived program need related to the effort to serve handicapped children.

We also feel that RAPs should function as more than service brokers. We believe that in order to be truly effective, RAPs must be funded to conduct their own training and technical assistance activities and pay for services provided to individual programs if these services cannot be provided in-kind or paid for out of local program funds. In other words, RAPs should be configured to help provide the supportive services which some programs presently lack.

Outreach and Recruitment

Data in Chapter 5 indicated that one of the basic differences between the Head Start and non-Head Start programs was that Head Start programs were more likely to enroll handicapped children through their own screening and outreach efforts rather than through referrals of children previously identified as handicapped by other agencies or professionals. In some respects, this must be considered a strong point of the Head Start handicapped effort because it indicates that Head Start is targeting on children whose disabilities would likely have gone unserved and unrecognized until their entry into the public school system.

We would be more positive about this aspect of the Head Start handicapped effort if it were not for the fact that nearly 60 percent of all the handicapped enrollees in our study sample were identified through normal recruitment and enrollment procedures. Very few of the sample children were recruited as a result of special outreach efforts designed to identify and serve handicapped children. What this indicates is that the majority of the children designated as handicapped came from the population Head Start might have served even without the mandate to enroll the handicapped.

SPECIFIC ISSUE:

HEAD START OUTREACH EFFORTS DO NOT APPEAR TO BE VERY EFFECTIVE IN LOCATING HANDICAPPED CHILDREN IN THE COMMUNITY.

RECOMMENDATION

ACYF SHOULD MAKE ARRANGEMENTS FOR INCREASED TRAINING AND TECHNICAL ASSISTANCE IN RECRUITMENT AND OUTREACH TECHNIQUES DESIGNED TO IDENTIFY CHILDREN WITH POTENTIAL DISABILITIES. IN ADDITION, ACCOUNT 26 FUNDS SHOULD BE MADE AVAILABLE TO SPECIFICALLY SUPPORT THESE OUTREACH ACTIVITIES. THESE FUNDS SHOULD BE PROVIDED AT THE SAME TIME SCREENING FUNDS ARE PROVIDED (SEE P. 12.12).

RECOMMENDATION:

AT THE NATIONAL, STATE, AND LOCAL LEVELS, HEAD START NEEDS TO UPGRADE PROMOTIONAL EFFORTS TO INFORM NOT ONLY THE GENERAL PUBLIC BUT ALSO OTHER AGENCIES OF THE SERVICES HEAD START CAN PROVIDE TO HANDICAPPED CHILDREN.

SPECIFIC ISSUE:

HEAD START PROGRAMS ARE OFTEN UNAWARE, OR NOT A PART OF, STATE OR LOCAL CHILD FIND AND REFERRAL SYSTEMS.

Although 26 percent of the sample children investigated in this study came to Head Start through referrals, most of these were referrals which did not come from agencies that are routinely involved with the problems of the handicapped such as the Easter Seal programs, the Crippled Children Association, the Association for Retarded Citizens, etc. Because of the excellent opportunity for providing handicapped children a mainstreaming experience in a Head Start program, we believe that ACYF should take steps to encourage closer linkages between agencies such as those mentioned and Head Start. This cooperation could be greatly facilitated by establishing interagency agreements at the national and State levels.

Furthermore, few of the Head Start programs we visited were actively participating in child find and outreach projects currently in existence. While we have advocated more intensive outreach efforts on the part of individual programs, we also believe Head Start programs should make greater efforts to offer their services to children identified by other outreach networks. In brief, not only should more handicapped children be enrolled through special handicapped outreach activities, more children should also be enrolled through referrals from other agencies. The child-centered service model that Head Start is so actively pursuing demands greater interagency cooperation in the placement of special children than has been indicated to date.

RECOMMENDATION:

ACYF, PARTICULARLY AT THE REGIONAL LEVEL, SHOULD TAKE ACTION TO ENSURE THAT HEAD START GRANTEES ARE LINKED TO STATE AND/OR BEH-FUNDED CHILD OUTREACH PROJECTS AND OTHER REFERRAL SERVICES OPERATED BY AGENCIES SUCH AS ASSOCIATIONS FOR RETARDED CITIZENS, EASTER SEALS, UNITED CEREBRAL PALSY ASSOCIATION, AND EPSDT CLINICS. AT THE NATIONAL LEVEL, ACYF SHOULD ESTABLISH STRONG INTERAGENCY COORDINATION WITH THE CHILD HEALTH ASSESSMENT PROGRAM (CHAP) TO ENSURE THAT NEW FEDERAL EFFORTS IN THE AREA OF CHILD HEALTH INCLUDE ACYF INPUT.

SPECIFIC PROBLEM:

HEAD START PROGRAMS ARE UNSURE OF THEIR RESPONSIBILITIES CONCERNING PUBLIC LAW 94-142.

Effective outreach and recruitment of handicapped children in Head Start requires close cooperation with other agencies also serving the handicapped. As outlined in a previous recommendation, ACYF should take action to develop this cooperation. We believe that an essential step in establishing close interagency cooperation is the clarification of Head Start's position vis-a-vis PL 94-142.

Throughout the Phase I effort, field staff had the opportunity to observe ways in which PL 94-142 had directly effected the Head Start effort. This effort has generally been negative for two reasons. One, PL 94-142 has created an atmosphere of competition for enrollees between Head Start and programs required to comply with 94-142. Secondly, PL 94-142 is perceived as a standard for handicapped services which Head Start programs fail to meet. Furthermore, several Head Start programs expressed confusion and frustration as to how PL 94-142 did or did not apply to their particular efforts to serve handicapped children.

RECOMMENDATION:

ALTHOUGH PL 94-142 PERTAINS TO PROGRAMS OPERATED UNDER THE AUSPICES OF STATE EDUCATION AGENCIES, ACYF SHOULD TAKE STEPS TO FAMILIARIZE HEAD START PROGRAMS WITH THIS LEGISLATION AND TO PUBLICIZE THE SIMILARITIES BETWEEN THE PROVISIONS OF 94-142 AND THE HEAD START PERFORMANCE STANDARDS.

Implementation of this recommendation will help to eliminate this barrier to effective interagency cooperation, Head Start programs should be given information and training materials relating to PL 94-142 and its requirements and, on a State-by-State basis, be informed as to how these requirements affect Head Start operations. We also suggest that ACYF develop for distribution to all

State Education Agencies (SEAs) and Local Education Agencies (LEAs) an explanation of the relationship between the provisions of P.L. 94-142 and the Head Start performance standards so that perceived inconsistencies can be fully discussed and refuted. The recent ACYF brochure entitled "PL 94-142: What Does It Mean To Head Start?" is an example of the type of information that needs immediate and widespread distribution.

APPENDIX A

Auxilliary Analytical Tables

TABLE A3.1

Mode of Mainstreaming By Primary Handicap						
	Types of Mainstreaming					
Handicapping Condition	Complete, Without Supportive Assistance % of Column Row	Complete, With Supportive Assistance % of Column Row	Complete, Team Taught by Special Education Teacher and Regular Teacher % of Column Row	Reverse Mainstreaming % of Column Row	Partial Mainstreaming % of Column Row	No Mainstreaming % of Column Row
Visually Impaired/Blind	28.6 (N=6)	42.9 (N=9)	23.8 (N=5)	*	*	4.7 (N=1)
Hearing Impaired/Deaf	52.2 (N=12)	47.8 (N=11)	*	*	*	*
Physically Handicapped	43.2 (N=16)	43.2 (N=16)	2.7 (N=1)	8.2 (N=3)	2.7 (N=1)	*
Speech Impaired	32.2 (N=19)	61.0 (N=36)	1.7 (N=1)	1.7 (N=1)	3.4 (N=2)	*
Health/Developmentally Impaired	53.3 (N=16)	40.0 (N=12)	3.3 (N=1)	*	3.3 (N=1)	*
Mentally Retarded	45.7 (N=16)	45.7 (N=16)	5.7 (N=2)	*	*	2.8 (N=1)
Learning Disabled	32.2 (N=10)	45.2 (N=14)	*	*	19.4 (N=6)	3.2 (N=1)
Seriously Emotionally Disturbed	27.4 (N=9)	57.6 (N=19)	6.0 (N=2)	*	6.0 (N=2)	3.0 (N=1

TABLE A3.2

Mode of Mainstreaming by Level of Handicap Severity

	Types of Mainstreaming					
Severity Level	Complete, Without Supportive Assistance % of Column	Complete, With Supportive Assistance % of Column	Complete, Team Taught by Special Education Teacher and Regular Teacher % of Column	Reserve Mainstreaming % of Column	Partial Mainstreaming % of Column	No Mainstreaming % of Column
Mild	45.9 (N=28)	47.5 (N=29)	3.3 (N=2)	*	3.3 (N=2)	*
Moderate	44.1 (N=49)	45.9 (N=51)	3.6 (N=4)	1.8 (N=2)	2.7 (N=3)	1.8 (N=2)
Severe/Profound	28.8 (N=23)	55.0 (N=44)	3.8 (N=3)	2.5 (N=2)	8.8 (N=7)	1.3 (N=1)
Other	23.5 (N=4)	52.9 (N=9)	17.6 (N=3)	*	*	5.9 (N=1)

TABLE A3.3

Degree of Social Integration by Primary Handicap

Social Integration	Visually Impaired/ Blind % of Column	Hearing Impaired/ Deaf % of Column	Physically Handicapped % of Column	Speech Impaired % of Column	Health/ Developmentally Impaired % of Column	Mentally Retarded % of Column	Learning Disabled % of Column	Seriously Emotionally Disturbed % of Column
Not Socially Integrated	5.3 (N=1)	13.0 (N=3)	12.5 (N=7)	5.7 (N=1)	3.6 (N=1)	20.7 (N=6)	10.7 (N=3)	8.6 (N=2)
Somewhat Socially Integrated	10.5 (N=2)	17.4 (N=4)	18.8 (N=6)	20.8 (N=11)	14.3 (N=4)	31.0 (N=9)	32.1 (N=9)	52.2 (N=12)
Socially Integrated	84.2 (N=16)	69.6 (N=16)	68.7 (N=22)	73.5 (N=39)	82.1 (N=23)	48.3 (N=14)	57.1 (N=16)	52.2 (N=12)
TOTAL	19	23	32	53	28	29	28	23

[1/] Totals less than those indicated in Chapter 2 because observations could not be completed for 31 children.

TABLE A6.1

Distribution of Screening Completeness by Location of Program

Program Location	Not Reported % of Column	Complete Screening % of Column	Complete Plus Additional Screening % of Column	Partial Screening % of Column	Partial Plus Additional Screening % of Column
	Completeness of Screening				
Total**	100 (N=15)	100 (N=49)	100 (N=87)	100 (N=66)	100 (N=52)
Not Reported	6.7 (N=1)	4.1 (N=2)	6.9 (N=6)	1.5 (N=1)	7.6 (N=4)
Urban Location	73.3 (N=11)	38.8 (N=19)	40.2 (N=35)	57.6 (N=38)	48.1 (N=25)
Rural Location	20.0 (N=3)	57.1 (N=28)	52.9 (N=46)	40.9 (N=27)	44.2 (N=23)

TABLE A6.2

Type of Service Provider Who Performed Additional Screening in Each Screening Area

Screening Area	Total ** % by Row	Not Reported % by Row	Psychologist/ Psychiatrist % by Row	Pediatrician/ Other Licensed Medical Professional % by Row	Speech Therapist/ Audiologist % by Row	Para-professional Medical Personnel % by Row	Social Worker % by Row	Public Health Nurse % by Row	Interdisciplinary Team % by Row	Head Start Staff Teacher % by Row	Other % by Row
					Providers						
Vision	100 (N=269)	87.7 (N=236)	*	8.6 (N=23)	*	*	*	1.5 (N=4)	1.1 (N=3)	0.4 (N=1)	0.7 (N=2)
Hearing	100 (N=269)	79.6 (N=214)	*	3.3 (N=9)	12.6 (N=34)	*	*	1.9 (N=5)	1.5 (N=4	*	1.1 (N=3)
Physical Coordination and Development	100 (N=269)	81.4 (N=219)	7.1 (N=3)	7.4 (N=20)	1.5 (N=4)	*	*	0.7 (N=2)	4.5 (N=12	0.7 (N=2)	2.6 (N=7)
Speech and Language	100 (N=269)	72.5 (N=195)	1.1 (N=3)	1.5 (N=4)	16.4 (N=44)	*	*	0.4 (N=1)	4.5 (N=1)	*	3.7 (N=10)
Intellectual Development	100 (N=269)	83.3 (N=224)	5.2 (N=14)	0.7 (N=2)	1.1 (N=3)	*	*	*	5.2 (N=14)	0.4 (N=1)	4.1 (N=11)
Social/ Emotional Development	100 (N=269)	83.6 (N=225)	7.8 (N=21)	0.4 (N=1)	0.4 (N=1)	0.4 (N=1)	0.4 (N=1)	*	3.7 (N=10)	1.1 (N=3)	2.2 (N=6)

TABLE A6.3

Techniques Used for Head Start Regular Screening in Vision

Technique Type	% of Total
Not reported	16.4 (N=44)
Snellen Picture Chart	43.9 (N=118)
Opthamological Exam	5.2 (N=14)
Titmus	10.8 (N=29)
Sojourn Hand Test	0.4 (N=1)
Other formal (standardized) test	5.2 (N=14)
Observation	0.7 (N=2)
Locally designed instrument	*
Other	4.5 (N=12)
Don't know	13.0 (N=35)
Total**	100 (N=269)

TABLE A6.4

Techniques Used for Head Start Regular Screening in Hearing	
Technique Type	% of Total
Not reported	13.4 (N=36)
Pure Tone Sweep	2.6 (N=7)
Pure Tone Threshold	7.1 (N=19)
Impedence	4.5 (N=12)
Speech Reception Threshold/Speech Discrimination	*
Audiometric Exam-Technique not specified	43.5 (N=117)
Full Audiometric Exam (2 or more of the above Techniques)	8.6 (N=23)
Observation	1.1 (N=3)
Other formal (standardized) test	2.6 (N=7)
Don't know	16.7 (N=45)
Total**	100 (N=269)

TABLE A6.5

Techniques Used for Head Start Regular Screening in Physical Coordination and Development	
Technique Type	% of Total
Not reported	23.0 (N=62)
Physical exam	29.0 (N=78)
Learning Accomplishment Profile	2.6 (N=7)
Denver Developmental Screening Test	13.4 (N=36)
Cattel Infant Intelligence Test	1.1 (N=3)
Bayley Scales of Infant Development	0.4 (N=1)
Other formal (standardized) test	6.7 (N=18)
Observation	8.2 (N=22)
Locally designed assessment	1.9 (N=5)
Don't know	13.8 (N=37)
Total**	100 (N=269)

TABLE A6.6

Techniques Used for Head Start Regular Screening in Speech and Language Development	
Technique Type	% of Total
Not reported	23.8 (N=64)
Peabody Picture Vocabulary Test	8.2 (N=22)
Goldman Fristoe Test of Articulation	2.6 (N=7)
Carrow Test for Auditory Comprehension of Language	1.1 (N=3)
Zimmerman Pre-school Language Test	3.0 (N=8)
Illinois Test of Psycholinguistic Abilities	0.4 (N=1)
Other formal(standardized) test	24.2 (N=65)
Observation	11.9 (N=32)
Locally designed assessment	8.2 (N=22)
Don't know	16.7 (N=45)
Total**	100 (N=269)

TABLE A6.7

Techniques Used for Head Start Regular Screening in Intellectual Development

Technique Type	% of Total
Not reported	29.0 (N=78)
Denver Developmental Screening Test	14.1 (N=38)
Stanford-Binet	3.0 (N=8)
Cattell Infant Intelligence Test	*
Learning Accomplishment Profile	12.6 (N=34)
Bayley Scales of Infant Development	0.4 (N=1)
Other formal (standardized) test	11.5 (N=31)
Observation	7.1 (N=19)
Locally designed assessment	14.5 (N=39)
Don't know	7.8 (N=21)
Total**	100 (N=269)

TABLE A6.8

Techniques Used for Head Start Regular Screening in Social Emotional Development	
Technique Type	% of Total
Not reported	31.2 (N=84)
Denver Developmental Screening Test	13.0 (N=35)
Vineland Social Maturity Scale	1.9 (N=5)
Bayley Scales of Infant Development	*
Learning Accomplishment Profile	9.3 (N=25)
Other formal (standardized) test	5.2 (N=14)
Observation	17.1 (N=46)
Locally designed assessment	11.5 (N=31)
Other	0.7 (N=2)
Don't know	10.0 (N=27)
Total**	100 (N=269)

TABLE A6.9

Techniques Used for Head Start Additional Screening in Vision	
Technique Type	% of Total
Not reported	87.7 (N=236)
Snellen Picture Chart	0.7 (N=2)
Opthamological Exam	3.0 (N=8)
Titmus	0.7 (N=2)
Sojourn Hand Test	*
Other formal (standardized) test	0.7 (N=2)
Observation	*
Locally designed instrument	*
Other	1.1 (N=3)
Don't know	5.9 (N=16)
Total**	100 (N=269)

TABLE A6.10

Techniques Used for Head Start Additional Screening in Hearing	
Technique Type	% of Total
Not reported	80.3 (N=216)
Pure Tone Sweep	*
Pure Tone Threshold	0.7 (N=2)
Impedence	1.9 (N=5)
Speech Reception Threshold/Speech Discrimination	*
Audiometric Exam-Technique not specified	5.6 (N=15)
Full Audiometric Exam (2 or more of the above Techniques)	4.5 (N=12)
Observation	*
Other formal (standardized) test	0.7 (N=2)
Don't know	6.3 (N=17)
Total**	100 (N=269)

TABLE A6.11

Techniques Used for Head Start Additional Screening in Physical Coordination and Development	
Technique Type	% of Total
Not reported	81.4 (N=219)
Physical exam	4.8 (N=13)
Learning Accomplishment Profile	0.4 (N=1)
Denver Developmental Screening Test	0.7 (N=2)
Cattel Infant Intelligence Test	*
Bayley Scales of Infant Development	*
Other formal (standardized) test	3.7 (N=10)
Observation	0.4 (N=1)
Locally designed assessment	2.2 (N=6)
Don't know	6.3 (N=17)
Total**	100 (N=269)

TABLE A6.12

Techniques Used for Head Start Additional Screening in Speech and Language Development	
Technique Type	% of Total
Not reported	74.0 (N=199)
Peabody Picture Vocabulary Test	5.6 (N=15)
Goldman Fristoe Test of Articulation	0.4 (N=1)
Carrow Test for Auditory Comprehension of Language	0.7 (N=2)
Zimmerman Pre-school Language Test	0.4 (N=1)
Illinois Test of Psycholinguistic Abilities	1.5 (N=4)
Other formal (standardized) test	6.3 (N=17)
Observation	0.4 (N=1)
Locally designed assessment	2.2 (N=6)
Don't know	8.6 (N=23)
Total**	100 (N=269)

TABLE A6.13

Techniques Used for Head Start Additional Screening in Intellectual Development

Technique Type	% of Total
Not reported	84.0 (N=226)
Denver Developmental Screening Test	0.4 (N=1)
Stanford-Binet	3.0 (N=8)
Cattell Infant Intelligence Test	*
Learning Accomplishment Profile	*
Bayley Scales of Infant Development	0.4 (N=1)
Other formal (standardized) test	5.9 (N=16)
Observation	0.7 (N=2)
Locally designed assessment	1.9 (N=5)
Don't know	3.7 (N=10)
Total**	100 (N=269)

TABLE A6.14

Techniques Used for Head Start Additional Screening in Social Emotional Development	
Technique Type	% of Total
Not reported	84.0 (N=226)
Denver Developmental Screening Test	0.4 (N=1)
Vineland Social Maturity Scale	*
Bayley Scales of Infant Development	*
Learning Accomplishment Profile	*
Other formal (standardized) test	2.6 (N=7)
Observation	7.4 (N=20)
Locally designed assessment	2.2 (N=6)
Other	0.4 (N=1)
Don't know	3.0 (N=8)
Total**	100 (N=269)

TABLE A6.15

Techniques Used by Non-Head Start Programs for Screening in Vision

Technique Type	% of Total
Not reported	56.5 (N=26)
Snellen Picture Chart	19.6 (N=9)
Opthamological Exam	8.7 (N=4)
Titmus	*
Sojourn Hand Test	*
Other formal (standardized) test	2.2 (N=1)
Locally designed instrument	2.2 (N=1)
Other	2.2 (N=1)
Don't know	8.7 (N=4)
Total **	100 (N=46)

TABLE A6.16

Techniques Used by Non-Head Start Programs for Screening in Hearing

Technique Type	% of Total
Not reported	50.0 (N=23)
Pure Tone Sweep	4.3 (N=2)
Pure Tone Threshold	6.5 (N=3)
Impedence	2.2 (N=1)
Speech Reception Threshold/Speech Discrimination	*
Audiometric Exam-Technique not specified	23.9 (N=11)
Full Audiometric Exam (2 or more of the above techniques)	2.2 (N=1)
Observation	2.2 (N=1)
Other formal test	2.2 (N=1)
Don't know	6.5 (N=3)
Total**	100 (N=46)

TABLE A6.17

Techniques Used by Non-Head Start Programs for Screening in Physical Coordination and Development	
Technique Type	% of Total
Not reported	50.0 (N=23)
Physical exam	17.4 (N=8)
Learning Accomplishment Profile	2.2 (N=1)
Denver Developmental Screening Test	2.2 (N=1)
Cattel Infant Intelligence Test	2.2 (N=1)
Bayley Scales of Infant Development	*
Other formal (standardized) test	10.9 (N=5)
Observation	4.3 (N=2)
Locally designed assessment	6.5 (N=3)
Don't know	4.3 (N=2)
Total **	100 (N=46)

TABLE A6.18

Techniques Used by Non-Head Start Programs for Screening in Speech and Language Development	
Technique Type	% of Total
Not reported	50.0 (N=23)
Peabody Picture Vocabulary Test	10.9 (N=5)
Goldman Fristoe Test of Articulation	2.2 (N=1)
Carrow Test for Auditory Comprehension of Language	*
Zimmerman Pre-school Language Test	4.3 (N=2)
Illinois Test for Psycholinguistic Abilities	*
Other formal (standardized) test	8.7 (N=4)
Observation	4.3 (N=2)
Locally designed assessment	15.2 (N=7)
Don't know	4.3 (N=2)
Total**	100 (N=46)

TABLE A6.19

Techniques Used by Non-Head Start Programs for Screening in Intellectual Development	
Technique Type	% of Total
Not reported	47.8 (N=22)
Denver Developmental Screening Test	2.2 (N=1)
Stanford-Binet	6.5 (N=3)
Wechsler Intelligence Scale for Children	2.2 (N=1)
Learning Accomplishment Profile	2.2 (N=1)
Bayley Scales of Infant Development	4.3 (N=2)
Other formal (standardized) test	15.2 (N=7)
Observation	6.5 (N=3)
Locally designed assessment	8.7 (N=4)
Don't know	4.3 (N=2)
Total**	100 (N=46)

TABLE A6.20

Techniques Used by Non-Head Start Programs for Screening in Social Emotional Development

Technique Type	% of Total
Not reported	52.2 (N=24)
Denver Developmental Screening Test	2.2 (N=1)
Vineland Social Maturity Scale	10.9 (N=5)
Bayley Scales of Infant Development	*
Learning Accomplishment Profile	*
Other formal (standardized) test	8.7 (N=4)
Observation	13.0 (N=6)
Locally designed assessment	6.5 (N=3)
Other	2.2 (N=1)
Don't know	4.3 (N=2)
Total**	100 (N=46)

TABLE A7.1

Frequency of Diagnostic Confirmations Made in Each Diagnostic Area by Handicapping Condition

Confirmation	Total	Visually Impaired % of Column	Blind % of Column	Hearing Impaired % of Column	Deaf % of Column	Physical Handicap % of Column	Health or Developmentally Impaired % of Column	Speech Impaired % of Column	Specific Learning Disability % of Column	Mentally Retarded % of Column	Seriou Emotion Disturb % of C
Total		N=15	N=6	N=21	N=2	N=37	N=30	N=59	N=31	N=35	N=33
Vision	N=34	93.3 (N=14)	83.3 (N=5)	*	*	10.8 (N=4)	10.0 (N=3)	5.1 (N=3)	6.5 (N=2)	5.7 (N=2)	3.0 (N=1
Hearing	N=41	6.7 (N=1)	*	95.2 (N=20)	100.0 (N=2)	8.1 (N=3)	26.7 (N=8)	5.1 (N=3)	12.9 (N=4)	*	*
Physical Coordination/Development	N=102	6.7 (N=1)	16.7 (N=1)	28.6 (N=6)	*	94.6 (N=35)	80.0 (N=24)	11.9 (N=7)	38.7 (N=12)	37.1 (N=13)	9.1 (N=
Speech and Language	N=139	*	*	47.6 (N=10)	*	29.7 (N=11)	40.0 (N=12)	98.3 (N=58)	77.4 (N=24)	45.7 (N=16)	24.2 (N=8
Intellectual Development	N=87	*	*	23.8 (N=5)	*	16.2 (N=6)	30.0 (N=9)	18.6 (N=11)	74.2 (N=23)	77.1 (N=27)	18.2 (N=
Social/Emotional Development	N=73	*	*	23.8 (N=5)	*	10.8 (N=4)	26.7 (N=8)	13.6 (N=8)	41.9 (N=13)	31.4 (N=11)	72.7 (N=

Note: Each percentage was derived from the total number of cases within each handicap classification. Thus, the first cell shows that 14, or 93.3%, of the 15 cases in which visual impairment was reported as the primary handicapping condition, received a confirmation in the vision diagnostic area. The diagnostic areas of primary concern to each handicapping condition are enclosed in boxes.

TABLE A7.2

Techniques Used for Head-Start Confirmation of Handicap in Hearing

Technique Type	% of Total
Pure Tone Sweep	2.4 (N=1)
Pure Tone Threshold	4.9 (N=2)
Impedence	14.6 (N=6)
Speech Reception Threshold/Speech Discrimination	*
Audiometric Exam - Technique not specified	36.6 (N=15)
Full Audiometric Exam (2 or more of above techniques)	17.1 (N=7)
Other formal (standardized) test	4.9 (N=2)
Don't Know	19.5 (N=8)
Total**	100 (N=41)

TABLE A7.3

Techniques Used for Head Start Confirmation of Handicap in Speech and Language Development	
Technique Type	**% of Total**
Peabody Picture Vocabulary Test	28.6 (N=40)
Goldman Fristoe Test of Articulation	14.3 (N=20)
Carrow Test for Auditory Comprehension of Language	3.6 (N=5)
Zimmerman Preschool Language Test	2.9 (N=4)
Illinois Test of Psycholinguistic Abilities	1.4 (N=2)
Other formal (standardized) test	22.9 (N=32)
Observation	5.7 (N=8)
Locally designed assessment	3.6 (N=5)
Don't Know	17.1 (N=24)
Total**	100 (N=140)

TABLE A7.4

Techniques Used for Head Start Confirmation of Handicap in Physical Coordination and Development

Technique Type	% of Total
Physical exam	46.6 (N=48)
Learning Accomplishment Profile	1.9 (N=2)
Denver Developmental Screening Test	5.8 (N=6)
Cattel Infant Intelligence Test	1.0 (N=1)
Bayley Scales of Infant Development	1.9 (N=2)
Other formal (standardized) test	16.5 (N=17)
Observation	6.8 (N=7)
Locally designed assessment	1.9 (N=2)
Don't know	17.5 (N=18)
Total**	100 (N=103)

TABLE A7.5

Techniques Used for Head Start Confirmation of Handicap in Intellectual Development	
Technique Type	% of Total
Denver Developmental Screening Test	5.7 (N=5)
Stanford Binet	29.9 (N=26)
Cattell Infant Intelligence Test	1.1 (N=1)
Learning Accomplishment Profile	3.4 (N=3)
Bayley Scales of Infant Development	1.1 (N=1)
Other formal (standardized) test	29.9 (N=26)
Observation	5.7 (N=5)
Locally designed assessment	1.1 (N=1)
Don't Know	21.8 (N=19)
Total**	100 (N=87)

TABLE A7.6

Techniques Used for Head Start Confirmation of Handicap in Social/Emotional Development

Technique Type	% of Total
Denver Developmental Screening Test	4.2 (N=3)
Vineland Social Maturity Scale	13.9 (N=10)
Bayley Scales of Infant Development	1.4 (N=1)
Learning Accomplishment Profile	5.6 (N=4)
Other formal (standardized) test	9.7 (N=7)
Observation	38.9 (N=28)
Locally designed assessment	2.8 (N=2)
Other	2.8 (N=2)
Don't Know	20.8 (N=15)
Total**	100 (N=72)

TABLE A7.7

Techniques Used for Head Start Confirmation of Handicap in Vision

Technique Type	% of Total
Snellen Picture Chart	5.9 (N=2)
Opthamological Exam	35.3 (N=12)
Titmus	2.9 (N=1)
Sojourn Hand Test	*
Other formal (standardized) test	2.9 (N=1)
Observation	*
Locally designed instrument	*
Other	2.9 (N=1)
Don't Know	50.0 (N=17)
Total**	100 (N=34)

TABLE A7.8

Cases Where the Parents of Head Start Handicapped Children were Included As Part of a Diagnostic Team	
Parent Inclusion In Diagnostic Team	% of Total
Not reported	0.7 (N=2)
Parents were included as part of the diagnostic team	65.8 (N=177)
Parents were not included as part of the diagnostic teams	33.5 (N=90)
Total**	100 (N=269)

TABLE A7.9

Professionals Who Provided Functional Assessment in Non-Head Start Programs by Diagnostic Area

Diagnostic Area	Provider of Functional Assessment						
	Psychologist/ Psychiatrist	Pediatrician/ Other Licensed Medical Professional	Speech Therapist/ Audiologist	Parapro- fessional Medical Personnel	Interdiscip- plinary Team	Staff Teacher	Other 1/
Vision	4.3 (N=2)	47.8 (N=22)	2.2 (N=1)	*	13.0 (N=6)	4.3 (N=2)	17.4 (N=8)
Hearing	*	26.1 (N=12)	52.2 (N=24)	2.2 (N=1)	13.0 (N=6)	4.3 (N=2)	17.4 (N=8)
Physical Coordination and Development	8.7 (N=4)	45.7 (N=21)	*	2.2 (N=1)	23.9 (N=11)	17.4 (N=8)	32.6 (N=15)
Intellectual Development	60.9 (N=28)	4.3 (N=2)	*	*	32.6 (N=15)	15.2 (N=7)	13.0 (N=6)
Speech and Language Development	2.2 (N=1)	2.2 (N=1)	71.7 (N=33)	*	19.6 (N=9)	13.0 (N=6)	10.9 (N=5)
Social/Emotional Development	52.2 (N=24)	*	2.2 (N=1)	*	28.3 (N=13)	23.9 (N=11)	23.9 (N=11)

1/ Includes social worker and public health nurse

Note: programs were allowed to respond more than once. Percentages were derived from total number of non-Head Start programs (46).

TABLE A7.10

Professionals Who Made Recommendations in Non-Head Start Programs by Diagnostic Area

Diagnostic Area	Provider of Recommendations						
	Psychologist/ Psychiatrist	Pediatrician Other Licensed Medical Professional	Speech Therapist/ Audiologist	Paraprofessional Medical Personnel	Interdisciplinary Team	Staff Teacher	Other[1]
Vision	2.2 (N=1)	39.1 (N=18)	*	*	17.4 (N=8)	15.2 (N=7)	17.4 (N=8)
Hearing	*	23.9 (N=11)	47.8 (N=22)	2.2 (N=1)	23.9 (N=11)	8.7 (N=4)	8.7 (N=4)
Physical Coordination and Development	6.5 (N=3)	43.5 (N=20)	*	2.2 (N=1)	32.6 (N=15)	15.2 (N=7)	26.1 (N=12)
Intellectual Development	54.3 (N=25)	2.2 (N=1)	*	*	41.3 (N=19)	13.0 (N=6)	10.9 (N=5)
Speech and Language Development	4.3 (N=2)	*	58.7 (N=27)	*	28.3 (N=13)	10.9 (N=5)	13.0 (N=6)
Social/Emotional Development	50.0 (N=23)	*	4.3 (N=2)	*	30.4 (N=14)	21.7 (N=10)	23.9 (N=11)

[1] Includes social worker and public health nurse

Note: Total numbers vary because programs were allowed to respond more than once. Percentages were derived from total number of non-Head Start programs (46).

TABLE A7.11

Reasons for Using Diagnosticians in Non-Head Start Programs by Each Diagnostic Area

Diagnostic Area	Reasons							
	Total** % of Row	Least expensive service available % of Row	Best service available % of Row	Only available service % of Row	Part of established diagnostic service % of Row	No choice, children usually diagnosed prior to enrollment % of Row	Other % of Row	No response % of Row
Vision	100 (N=46)	6.5 (N=3)	28.3 (N=13)	6.5 (N=3)	21.7 (N=10)	6.5 (N=3)	8.7 (N=4)	21.7 (N=10)
Hearing	100 (N=46)	6.5 (N=3)	28.3 (N=13)	2.2 (N=1)	37.0 (N=17)	6.5 (N=3)	10.9 (N=5)	8.7 (N=4)
Physical Coordination and Development	100 (N=46)	4.3 (N=2)	28.3 (N=13)	8.7 (N=4)	34.8 (N=16)	4.3 (N=2)	8.7 (N=4)	10,9 (N=5)
Speech and Language	100 (N=46)	4.3 (N=2)	30.4 (N=14)	6.5 (N=3)	41.3 (N=19)	6.5 (N=3)	6.5 (N=3)	4.3 (N=2)
Intellectual Development	100 (N=46)	4.3 (N=2)	23.9 (N=11)	10.9 (N=5)	45.7 (N=21)	6.5 (N=3)	6.5 (N=3)	2.2 (N=1)
Social/Emotional Development	100 (N=46)	4.3 (N=2)	26.1 (N=12)	4.3 (N=2)	43.5 (N=20)	6.5 (N=3)	6.5 (N=3)	8.7 (N=4)

TABLE A7.12

Techniques Used by Non-Head Start Programs for Confirmation of Handicap in Speech and Language Development

Technique Type	% of Total
Peabody Picture Vocabulary Test	23.9 (N=11)
Goldman Fristoe Test of Articulation	8.7 (N=4)
Carrow Test for Auditory Comprehension of Language	*
Zimmerman Pre-school Language Test	10.9 (N=5)
Illinois Test of Psycholinguistic Abilities	10.9 (N=5)
Other formal (standardized) test	47.8 (N=22)
Observation	2.2 (N=1)
Locally designed assessment	17.4 (N=8)
Don't know	8.7 (N=4)
Not reported	23.9 (N=11)

Note: Percentages were derived from total number of non-Head Start programs (46). Programs were allowed to respond more than once.

TABLE A7.13

Techniques Used by Non-Head Start Programs for Confirmation of Handicap in Physical Coordination and Development	
Technique Type	% of Total
Physical exam	23.9 (N=11)
Learning Accomplishment Profile	4.3 (N=2)
Denver Developmental Screening Test	4.3 (N=2)
Cattel Infant Intelligence Test	2.2 (N=1)
Bayley Scales of Infant Development	4.3 (N=2)
Other formal (standardized) test	30.4 (N=14)
Observation	4.3 (N=2)
Locally designed assessment	15.2 (N=7)
Don't know	8.7 (N=4)
Not reported	28.3 (N=13)

Note: Percentages were derived from total number of non-Head Start programs (46). Programs were allowed to respond more than once.

TABLE A7.14

Techniques Used by Non-Head Start Programs for Confirmation of Handicap in Intellectual Development

Technique Type	% of Total
Denver Developmental Screening Test	6.5 (N=3)
Stanford-Binet	30.4 (N=14)
Weschler Intelligence Scale for Children	15.2 (N=7)
Learning Accomplishment Profile	4.3 (N=2)
Bayley Scales of Infant Development	8.7 (N=4)
Other formal (standardized) test	52.2 (N=24)
Observation	4.3 (N=2)
Locally designed assessment	6.5 (N=3)
Don't know	4.3 (N=2)
Not reported	21.7 (N=10)

Note: Percentages were derived from total number of non-Head Start programs (46). Programs were allowed to respond more than once.

TABLE A7.15

Techniques Used by Non-Head Start Programs for Confirmation of Handicap in Social Emotional Development	
Technique Type	% of Total
Denver Developmental Screening Test	6.5 (N=3)
Vineland Social Maturity Scale	28.3 (N=13)
Bayley Scales of Infant Development	*
Learning Accomplishment Profile	2.2 (N=1)
Other formal (standardized) test	28.3 (N=13)
Observation	26.1 (N=12)
Locally designed assessment	8.7 (N=4)
Other	4.3 (N=2)
Don't know	4.3 (N=2)
Not reported	32.6 (N=15)

Note: Percentages were derived from total number of non-Head Start programs (46). Programs were allowed to respond more than once.

TABLE A7.16

Techniques Used by Non-Head Start Programs
for Confirmation of Handicap in Vision

Technique Type	% of Total
Snellen Picture Chart	13.0 (N=6)
Opthamological Exam	15.2 (N=7)
Titmus	2.2 (N=1)
Sojourn Hand Test	*
Other formal (standardized) test	17.4 (N=8)
Observation	2.2 (N=1)
Locally designed instrument	2.2 (N=1)
Other	4.3 (N=2)
Don't know	15.2 (N=7)
Not reported	45.7 (N=21)

Note: Percentages were derived from total number of non-Head Start programs (46). Programs were allowed to respond more than once.

TABLE A7.17

Techniques Used by Non-Head Start Programs for Confirmation of Handicap in Hearing	
Technique Type	% of Total
Pure Tone Sweep	4.3 (N=2)
Pure Tone Threshold	13.0 (N=6)
Impedence	4.3 (N=2)
Speech Reception Threshold/Speech Discrimination	*
Audiometric Exam-Technique not specified	34.8 (N=16)
Full Audiometric Exam (2 or more of the above techniques)	10.9 (N=5)
Observation	*
Other formal test	13.0 (N=6)
Don't know	10.9 (N=5)
Not reported	28.6 (N=13)

Note: Percentages were derived from total number of non-Head Start programs (46). Programs were allowed to respond more than once.

APPENDIX B

Phase I Data Collection Instruments

GOOD (MORNING, AFTERNOON), MY NAME IS ____________________, AND I REPRESENT APPLIED MANAGEMENT SCIENCES OF SILVER SPRING, MARYLAND. WE'RE UNDER CONTRACT TO THE OFFICE OF CHILD DEVELOPMENT TO REVIEW EFFORTS BEING MADE BY HEAD START PROGRAMS ON BEHALF OF HANDICAPPED CHILDREN. THE PURPOSE OF THIS INTERVIEW IS TWO-FOLD. FIRST WE WOULD LIKE TO OBTAIN INFORMATION ABOUT THE PROBLEMS YOU HAVE HAD IN ENROLLING HANDICAPPED CHILDREN AND THE NUMBER OF AND TYPES OF HANDICAPPED CHILDREN IDENTIFIED BY YOUR PROGRAM THAT YOU WERE NOT ABLE TO ENROLL. SECONDLY, WE WOULD ALSO LIKE TO HAVE INFORMATION CONCERNING THE RESOURCES YOU HAVE OBTAINED TO SUPPORT YOUR HANDICAPPED PROGRAM.

PLEASE REALIZE THAT IN ANALYZING THIS INFORMATION, ALL DATA WILL BE AGGREGATED SO THAT INDIVIDUAL PROGRAMS WILL NOT, AND CANNOT, BE IDENTIFIED. THIS STUDY IS NOT INTENDED TO BE A COMPLIANCE EVALUATION.

WE APPRECIATE YOUR TIME AND COOPERATION IN THIS STUDY. PLEASE FEEL FREE TO PROVIDE ANY INFORMATION YOU CAN IN RESPONSE TO THE QUESITONS WE'RE ASKING. ALSO, BE AS OPEN AND AS HONEST AS POSSIBLE WITH YOUR ANSWERS.

ARE THERE ANY QUESTIONS?

LET'S BEGIN.

OMB # 85-S77002
Expires: 12 / 31 / 77

EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I PRIMARY DATA INTERVIEW SCHEDULE

CARD COLUMN

1. Grantee ________________
2. Delegate Agency ________________

Program Code: ☐☐☐☐☐ 1-5

Respondent: ________________
(position/function)

Child Code: *(Leave blank)* ☐☐☐☐☐ 6-10

Program Name: ________________

Center Code: *(Leave blank)* ☐☐☐ 1-13

Form Number: 0 1 14-15

Interview Date __/__/__

Interviewer ________________

PART I - Handicapped Children Identified But Not Enrolled

FIRST, I'D LIKE TO ASK SOME QUESTIONS ABOUT CHILDREN THAT YOU HAVE SCREENED/IDENTIFIED (OR WERE REFERRED TO YOU) AS POTENTIALLY HANDICAPPED AND WHOM YOU WERE UNABLE TO ENROLL.

16-17 = "01"

1. Do you have a list of children with suspected or confirmed handicaps waiting to enroll in your program?

18
- 2 No
- 1 Yes

→ Please indicate the numbers of these children by handicapping condition

19-21	Blindness (1)	☐☐☐
22-24	Visual Impairment (2)	☐☐☐
25-27	Deafness (3)	☐☐☐
28-30	Hearing Impairment (4)	☐☐☐
31-33	Physical Handicap (5)	☐☐☐
34-36	Speech Impairment (6)	☐☐☐
37-39	Health or Developmental Impairment (7)	☐☐☐
40-42	Mental Retardation (8)	☐☐☐
43-45	Serious Emotional Disturbance (9)	☐☐☐
46-48	Specific Learning Disability (10)	☐☐☐

2. If an opening becomes available in your program, how do you determine who will fill the vacancy? (*Circle one*)

49
- 1 inappropriate, not relevant
- 2 child is selected who has been on the waiting list longest, regardless of whether he/she is handicapped
- 3 we would tend to enroll a handicapped child
- 4 we would tend to enroll a non-handicapped child
- 5 it depends on the child who left the program
- 6 other (*please specify*) ______________________________

3. If you had the option would you prefer to enroll one type of handicapped child over another?

2 No

50 1 Yes

Which handicap(s) would you prefer?

-52,53-54,55-56,57-58 ☐☐ ☐☐ ☐☐ ☐☐

(Interviewer: enter codes from #1).

4. Have you referred handicapped children to other programs in your community? *(Interviewer: Make certain that the respondent understands that this question refers to children who* ***could*** *have enrolled in Head Start but were* ***not****.)*

2 No

59 1 Yes

↳ 4a. If so, please indicate the number of these children by handicapping condition and the number of these children who were substantially or severely handicapped.

	Handicapping Condition	Number of Children	Number Severely/ Substantially Handicapped
60-61,62-63	Blindness	☐☐	☐☐
64-65,66-67	Visual Impairment	☐☐	☐☐
68-69,70-71	Deafness	☐☐	☐☐
72-73,74-75	Hearing Impairment	☐☐	☐☐
76-77,78-79	Physical Handicap	☐☐	☐☐
16-17 = "02" 18-19,20-21	Speech Impairment	☐☐	☐☐
22-23,24-25	Health or Development Impairment	☐☐	☐☐
26-27,28-29	Mental Retardation	☐☐	☐☐
30-31,32-33	Serious Emotional Disturbance	☐☐	☐☐
34-35,36-37	Specific Learning Disability	☐☐	☐☐
38-39,40-41	Other *(please specify)* ____________________ ____________________	☐☐	☐☐
42-44,45-47	TOTALS	☐☐☐	☐☐☐

4b. How many children would you estimate were referred to your program or screened by your program as potentially handicapped during this program year?

48-50 ☐☐☐

(On the basis of responses to 4a and 4b, calculate the percentage of potentially handicapped children encountered by this program who were referred to other agencies.) (This will be completed during editing)

51-52 *Enter here* ☐☐ *(divide 4b by total in 4a)*

4c. Please indicate the agencies to which you have referred handicapped children. Of these agencies, which would you estimate has received most of your referrals? *(Check all agencies utilized)*

53 ___ public schools (1)
54 ___ Easter Seal Agency (2)
55 ___ Association for Crippled Children (3)
56 ___ BEH First Chance Project (4)
57 ___ University Affiliated Program (5)
58 ___ other private categorical program (6)
59 ___ other private non-categorical program (7)
60 ___ State insitution (8)
61 ___ other Head Start program (9)
62 ___ other *(please specify)* ______________________________ (10)

63-64 4d. Enter code of agency most often used ☐☐

5. In your efforts to enroll handicapped children, have you encountered any situations in which your agency was competing with another to enroll a particular child?

65 3 No
2 No, but the possibility for conflict exists
1 Yes

5a. With which agencies have you had these conflicts (or potential conflicts)? *(Check all that apply)*

66 ___ public schools
67 ___ Easter Seal
68 ___ BEH First Chance Project
69 ___ University Affliated Program
70 ___ other private categorical program
71 ___ other private non-categorical program
72 ___ State institution
73 ___ Other Head Start program
74 ___ other *(please specify)* ____________________

5b. What was the basis of these conflicts? *(Check all that apply)*

75 ___ dispute over most appropriate placement for services

76 ___ dispute basically a matter of obtaining children for funding purposes

77 ___ Head Start and other agency(s) serve the same geographic area

78 ___ other *(please specify)* ______________________________

PART II - Clerical Data

16-17 ="03" Please complete this section prior to Applied Management Sciences' on-site visit. If you should have any questions about the information required, please contact Applied Management Sciences at either of the following toll-free numbers: 800-638-2784 or 800-638-2785

6. Based on your experience during the previous program year, what were the conditions of discontinuation of handicapped children in your program? *(Enter specific numbers for all that apply)*

	Conditions of Termination	Number of Children	
18-19	A Voluntary withdrawal	☐☐	Total Voluntary
20-21	moved	☐☐	
22-23	parental dissatisfaction with program	☐☐	
24-25	child no longer needed the program	☐☐	
26-27	child transfered to another program	☐☐	
28-29	unknown	☐☐	
30-31	B Termination by Center	☐☐	Total Center Termination
32-33	classroom management difficulties	☐☐	
34-35	age ineligible	☐☐	
36-37	entrance into public school system - special class	☐☐	
38-39	inability of staff to deal with handicap	☐☐	
40-41	entrance into other service program	☐☐	

7. For those handicapped children who are discontinued, are provisions made to ensure continuity of services?

42
2 No
1 Yes
→ Are such provisions made for both voluntary and center terminations?

43
2 No
1 Yes

8. What is the total number of children in your program who are:

44-46 handicapped and above OCD income guidelines ☐☐☐

47-49 handicapped and within OCD income guidelines ☐☐☐

50-52 non-handicapped and above OCD income guidelines ☐☐☐

53-55 non-handicapped and within OCD income guidelines ☐☐☐

9. Please indicate the number of handicapped children you serve by chronological age.

56-58 3 years old ☐☐☐

59-61 4 years old ☐☐☐

62-64 5 years old ☐☐☐

65-67 Other _____ ☐☐☐
(specify)

9a. Of your currently enrolled handicapped children, how many have been, or will be, in your program two or more years?

68-70 ☐☐☐ *(indicate number)*

10. How long has your program been providing services to handicapped children? *(Circle appropriate response code)*

71
1 one year
2 two years
3 three years
4 four years
5 five years
6 more than five years

11. What is your total funding *(in dollars)* for Fiscal Year 1977?
(Including program account 26)

72-77 $ ☐☐☐☐☐☐

16-17 = "04"

12. Of these funds, which have you specifically earmarked (all or a portion of) for services to the handicapped. Please indicate source, amount, and length of time you have received these funds.

	Source of Funds (enter appropriate code)	Amount (enter figure)	Number of Years Received (enter number)
18-19,20-25,26-27	☐☐	☐☐☐☐☐☐	☐☐
28-29,30-35,36-37	☐☐	☐☐☐☐☐☐	☐☐
38-39,40-45,46-47	☐☐	☐☐☐☐☐☐	☐☐
48-49,50-55,56-57	☐☐	☐☐☐☐☐☐	☐☐
58-59,60-65,66-67	☐☐	☐☐☐☐☐☐	☐☐
68-69,70-75,76-77	☐☐	☐☐☐☐☐☐	☐☐
16-17 = "05" 18-19,20-25,26-27	☐☐	☐☐☐☐☐☐	☐☐
28-29,30-35,36-37	☐☐	☐☐☐☐☐☐	☐☐

Codes for Funding Source

1 Basic Head Start grant

2 Head Start Supplemental funds

3 BEH First Chance funds

4 State "reimbursement of services" funds

5 other State funds

6 other local funds

7 other Federal funds

8 other Education for the Handicapped Act funds

9 other (*please specify*) ____________________

10 other (*please specify*) ____________________

13. Do you receive inkind services for the handicapped children in your program?

38 2 No

1 Yes

→ *(Please provide the following information only if inkind services are a major segment of your program)*

What services are provided?	Who/what agency provides the services?	Estimate of dollar value

39-44 TOTAL ☐☐☐☐☐☐

14. Please check all the entrance requirements for a handicapped child to qualify for enrollment into your program.

45 ___ chronological age

46 ___ certain handicapping condition(s)

47 ___ certain severity level of these handicapping conditions

48 ___ must be ambulatory

49 ___ must be toilet trained

50 ___ must be functioning at a minimum developmental level

51 ___ parents must make a commitment to participate in the program

52 ___ family must meet income guidelines

53 ___ other *(please specify)* ________________________________

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EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.
PHASE I

SECONDARY DATA INSTRUMENT

GRANTEE ______________________

DELEGATE AGENCY ______________________

CARD COLUMN		
1-5	Program Code	☐☐☐☐☐
6-10	Child Code *(Leave blank)*	☐☐☐☐☐
11-13	Center Code *(Leave blank)*	☐☐☐
4-15	Form Number	0 2

NAME ______________________

DATE ____ / ____ / ____
Yr. Mo. Day

FIFTH ANNUAL REPORT QUESTIONS

-17 = "01" *Interviewer: The following questions are taken from the Fifth Annual Report. To the far right you will find the reference page and question number. Please transcribe data from the Annual Report.*

PART I: GENERAL INFORMATION

(1) What is the total number of Head Start centers in your current Program? ☐☐☐ — p.4, #1,2,2b,3

18-20

(1a) What is the total number of children enrolled in your current Program?

- -24 Total number of children in Program ☐☐☐☐
- -27 Total number of children identified as handicapped by screening ☐☐☐
- -30 Total number of handicapped children confirmed by professional diagnosis ☐☐☐

-32 (1b) In how many of these centers is at least one handicapped child present? ☐☐

-34 (1c) What is the total number of classes at all centers in your current Program? ☐☐

-36 (1d) In how many of these classes is at least one handicapped child present? ☐☐

-38 (1e) Generally, what is the ratio of handicapped children to non-handicapped children? *(Computed by interviewer)* ☐☐

(2) Do you have special procedures, activities and resources for identifying preschool handicapped? — p.5, #4

39

2 No

1 Yes

→ Please describe ______________________________

____

(3) Were there any handicapped children (age and income eligible) who were located by you, or referred to you, but who you were not able to enroll in your current Head Start Program? p.7, #6

40
2 No...All handicapped children who were located or referred were enrolled *(Go to Question #4)*

1 Yes..Some handicapped children were not enrolled

→ If Yes...How many handicapped children located or referred were you not able to enroll?

41-42 ☐☐

(3a) If Yes...Please indicate the reasons why these children were not enrolled. *(Please check all that apply)*

43 ___ Did not meet income guidelines
44 ___ No available openings
45 ___ Lack of appropriate staff training
46 ___ Lack of suitable facilities or equipment
47 ___ Other agencies serve these children
48 ___ Concern over possible legal liabilities
49 ___ Classroom management problems
50 ___ Handicap too severe for child to benefit from Head Start
51 ___ Felt child's attendance would be detrimental to other children
52 ___ Child's parent refused
53 ___ Other parents or parent advisory group objected
54 ___ Lack of adequate transportation
55 ___ other *(please specify)* ____________________

(4) Indicate the number of professionally-diagnosed handicapped children according to the primary area of handicapping condition. *(Do not count the same child more than once.)*

56-58 ☐☐☐ Blindness p.23, #34
59-61 ☐☐☐ Visual Impairment p.28, #52
62-64 ☐☐☐ Deafness p.33, #65
65-67 ☐☐☐ Hearing Impairment p.38, #78

68-70	☐☐☐	Physical Handicap	p.43, #91
71-73	☐☐☐	Speech Impairment	p.49, #105
74-76	☐☐☐	Health or Developmental Impairment	p.55, #119
77-79 16-17 = "02"	☐☐☐	Mental Retardation	p.61, #133
18-20	☐☐☐	Serious Emotional Disturbance	p.66, #146
21-23	☐☐☐	Specific Learning Disabilities	p.71, #159
24-26	☐☐☐	Total (*Computed by interviewer*)	

(5) Are there currently in your Program staff members functioning for the primary or exclusive purpose of providing special assistance to handicapped children? p. 9, #11

27
2 No
1 Yes ↳

28-29	☐☐	Number of full-time teaching staff	
30-31	☐☐	Number of part-time teaching staff	
32-33	☐☐	Number of full-time specialist staff	
34-35	☐☐	Number of part-time specialist staff	
36-37	☐☐	Number of volunteers	p. 9, #12

(6) Is any outside agency (other than Head Start funding source) providing additional staff to your current Program for the primary or exclusive purpose of providing special assistance to handicapped children?

38
2 No
1 Yes ↳

39-40 ☐☐ Number of additional outside staff

(7) Is there any person (or persons) at the delegate agency or grantee level who is responsible for coordinating services for handicapped children in your current Program? p. 8, #10

41
2 No
1 Yes
→ If yes...is this person (or persons) working full-time or part-time?

42
1 Full-time
2 Part-time

(8) Has any preservice training about handicapped children been provided to your current Program staff?

43
2 No
1 Yes
→ How many staff members have participated in this training? p.10, #14 p.10, #15 p.10, #16

44-45 ☐☐ Number of staff members participating

(9) On the average, how many hours of preservice training did each participating staff member receive?

46-47 ☐☐ Average number of hours per staff member

(10) Which agency/organization provided the preservice training? *(Check all that apply)*

48 ___ Local Head Start program
49 ___ HEW/OCD contractors (including STOs, universities and colleges under contract to OCD)
50 ___ HEW/BEH funded training institutions
51 ___ Other Universities and colleges
52 ___ Special purpose agencies (Crippled Children Services, Cerebral Palsy Foundation, Association for Retarded Children, etc.)
53 ___ Other *(please specify)* ______________________
____
____

(11) Has any inservice training been provided or currently being provided about handicapped children to your current Program staff? p.12, #19

54
2 No, there was no training provided or being provided
1 Yes, training has been or is being provided

(12) How many of your current Head Start staff members have or are participating in this training? — p.12, #20

-56 ☐☐ Number of staff members who have or are participating

(13) On the average, about how many hours of this training did or is each participating staff member receiving? — p.12, #21

57-58 ☐☐ Average number of hours per staff member

(14) Please check below the topics or subjects of the training which have been or is currently being provided to your current Program staff. (*Check all that apply*) — p.13, #23

59 ___ Child development

60 ___ Recognition of handicapping conditions

61 ___ Techniques of screening, diagnosis and assessment

62 ___ Special education and curricula for handicapped children

63 ___ Integration, "mainstreaming" of handicapped children in the classroom

64 ___ Physical therapy for handicapped children

65 ___ Psychological problems of handicapped children

66 ___ The health and medical needs of handicapped children

67 ___ Working with the parents and families of handicapped children

68 ___ Attitudes and sensitivity of persons working with handicapped children

69 ___ Finding and obtaining the special resources/services needed by handicapped children

70 ___ Specialized, in-depth training for the purpose of recognizing, understanding, and dealing with specific disabilities:

71 ___ blindness, visual impairment

72 ___ deafness, hearing impairment

73 ___ speech impairment (communication disorder)

74 ___ physical handicap

75 ___ health or developmental impairment

76 ___ serious emotional disturbance

77 ___ mental retardation

78 ___ specific learning disabilities

79 ___ Emergency first-aid

80 ___ Other training (*please specify*) ______________________

____

____

6-17 = "03" (15) Have you received any technical assistance from other agencies to help you determine the need for or plan for training of handicapped children? p.21, #37

18 4 No...and none is/was needed

3 No...but some technical assistance would be or would have been helpful

2 Yes..and additional technical assistance would be or would have been helpful

1 Yes..and it was sufficient

↳ If yes...what agency/organization provided the technical assistance? (*Check all that apply*)

19 ___ HEW/OCD Contractors (including STO's, universities and colleges under contract to OCD)

20 ___ HEW/BEH funded training institutions

21 ___ Other universities and colleges

22 ___ Special purpose agencies (Crippled Children Services, Cerebral Palsy Foundation, Association for Retarded Children, etc.)

23 ___ Other (*please specify*) ______________________________

____

(16) Do any of the handicapped children enrolled in your current Head Start Program require modifications in the physical facilities of the Head Start classroom or centers? p.17, #28

24 1 No...no special modifications in physical facilities are required

2 Yes..special modifications in physical facilities were required and have already been made

3 Yes..special modification in physical facilities are required and are scheduled to be made before the end of the current Program

4 Yes..special modifications in physical facilities are required but there are no definite plans to make any

5 If special modifications in physical facilities have been made please describe. (Continued on next page)

(Interviewer: Fill in the remaining section from descriptions found on page 16.)

What changes were made? ______________________________

____

____

When were these changes made? ______________________________

03 ______________________________

____

For what handicapping conditions were these changes made?

____

____

____

5-28 Number of children for which these changes were made: ☐☐☐☐

29-33 Estimated total cost of these changes $ ☐☐☐☐☐

(17) Have any special materials or equipment for handicapped children been acquired or being acquired for your current Head Start Program? p.17, #29

34
2 No
1 Yes

→ From the list below, please indicate those types of special equipment or materials which you have already acquired or are acquiring before the end of the current Program. *(Check all that apply.)*

35 ___ Special transportation equipment p.17, #30
36 ___ Special chairs, beds, wheelchairs, or other furniture
37 ___ Special toys or equipment to develop fine or gross motor skills
38 ___ Special audiovisual aids for the handicapped
39 ___ Special books, charts or other instructional materials
40 ___ Special language/speech development materials
41 ___ Special instructional materials for parents of handicapped children
42 ___ Special materials and references for staff development
43 ___ Other *(please specify)* ______________________________

____

____

(17a) What is the appropriate cost of these materials and special equipment?

44-48 $ ☐☐☐☐☐ p.18, #31

(17b) In addition to the special equipment or materials which you have already acquired or are acquiring, is there any other special equipment or materials which your program needs? p.19, #1

2 No

49 1 Yes..if yes, from the list below, please indicate those types of special equipment or materials which are needed, but have not been acquired and are not definitely planned.

50 ___ Special transportation equipment

51 ___ Special chairs, beds, wheelchairs, or other furniture

52 ___ Special toys or equipment to develop fine or gross motor skills

53 ___ Special audiovisual aids for the handicapped

54 ___ Special books, charts or other instructional materials

55 ___ Special language/speech development materials

56 ___ Special instructional materials for parents of handicapped children

57 ___ Special materials and references for staff development

58 ___ Other *(please specify)* ______________________

____

____

(17c) If yes, please indicate the reasons those types of special equipment or materials which are needed and have not been acquired and are not definitely planned:

59 1 Child with special needs recruited for the following year

2 Diagnosis on child with special needs recently completed indicating need for special equipment or materials

3 Other *(please specify)* ______________________

____

____

OMB # 35-S77002
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EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I
FACILITIES WALK-THROUGH CHECKLIST - SECTION A

1. Grantee: ____________________
2. Delegate Agency: ____________________
3. Alternate Program: ____________________

CARD COLUMN

Program Code: ☐☐☐☐☐ 1

Program Name: ____________________

Child Code (*Leave blank*) ☐☐☐☐☐ 6-10

Center Code ☐☐☐ 11-13

Form Number | 0 | 3 | 14-15

Interviewer: ____________________

Walk-through Date: __/__/__

FACILITIES WALK-THROUGH CHECKLIST

SECTION A

INTERVIEWER:

THIS DOCUMENT SHOULD BE COMPLETED FOR EACH CHILD SELECTED FOR IN-DEPTH CASE STUDY. HOWEVER, IF MORE THAN ONE CHILD IS IN A CENTER ONE DOCUMENT CAN BE COMPLETED FOR THOSE CHILDREN. IF THE CHILDREN ARE LOCATED AT DIFFERENT CENTERS COMPLETE ONE OF THESE DOCUMENTS FOR EACH CHILD.

IF AN ALTERNATE PROGRAM IS INVOLVED, COMPLETE THIS DOCUMENT FOR ONE CLASSROOM USED BY AT LEAST ONE HANDICAPPED CHILD.

THIS FORM WAS NOT SUBMITTED FOR OMB APPROVAL BECAUSE NO RESPONDENT TIME IS REQUIRED TO OBTAIN THE INFORMATION NEEDED. HOWEVER, IF THE CLASSROOM TEACHER OR OTHER STAFF MEMBER DOES NOT OBJECT TO ASSISTING YOU, IT MAY BE HELPFUL TO SEEK THEIR ASSISTANCE.

PRIOR TO INITIATING YOUR WALK-THROUGH OBTAIN PERMISSION FROM THE HEAD START STAFF OR STAFF OF THE ALTERNATE PROGRAM INVOLVED. IF PERMISSION IS NOT GRANTED, DO NOT INSIST UPON YOUR REQUEST.

IF PERMISSION IS GRANTED, TRY TO CONDUCT YOUR WALK-THROUGH AS UNOBTRUSIVELY AS POSSIBLE. YOUR DEMEANOR SHOULD BE THAT OF LEARNING, NOT JUDGING, THE FACILITIES AVAILABLE TO THIS PROGRAM. FOR THIS SECTION OF THE WALK-THROUGH IT MAY BE DESIRABLE TO EXAMINE THE FACILITIES AND MATERIALS AT A TIME DURING THE DAY WHEN THE CLASSROOMS ARE EMPTY.

PLEASE MAKE NOTES AS YOU CONDUCT YOUR WALK-THROUGH OF ANY OUTSTANDING FACILITIES OR MATERIALS OBSERVED.

FACILITIES WALK THROUGH CHECKLIST

SECTION A

7="01" 1. What is the estimated square footage of the classroom in which this child is enrolled?

23 ☐☐☐☐☐☐ Square feet

2. Structural Facilities (*Check all that apply*)

___ Ramps

___ Doors to building can be pushed open by children

___ Doors to classroom can be pushed open by children

___ Doors to bathroom facilities can be pushed open by children

___ Wall to wall carpet in classroom

___ Large area rug in classroom

30 ___ Mats or throw rugs for resting and nap time

___ Bathroom in an easily accessible location

32 ___ Bathroom facilities are easily usable by handicapped and non-handicapped children (toilet is child-sized, can be easily flushed by child, toilet paper is within easy reach of child from toilet)

33 ___ Sink is in an easily accessible location in the classroom

___ Sink is easily usable by handicapped and non-handicapped children (low enough to floor for child to reach, children can work faucets without assistance, paper towels, soap, sponge within reach, etc.)

___ Play area inside

36 ___ Play area outside

___ Child size furniture and equipment (tables, shelves, etc.)

___ Room dividers

___ Lockers or special area for hanging coats, hats, rubbers and putting extra change of clothes

40 ___ Low open shelves for general storage and display of small toys and blocks (easily accessible by children)

___ High shelves or closed cabinets for teachers use

___ Teachers desk

___ First aid equipment

___ Open space for activities like block play, art and music

___ House play and dramatic play areas

23. Other *(specify)*: ______________________________

____

____

____

____

3. Housekeeping

General Condition of Environment *(Circle one)*

1 Excellent (clean; no odors; attractive displays; well lighted; etc.)

2 Good (no odors or visable filth, but lacks attractive interior; adequately lighted.)

3 Fair (no or poorly developed displays; odors, but no visible filth; poorly to fairly lighted.)

4 Poor (visible filth; dark.)

4. General Classroom Equipment *(Check all that apply)*

___ Materials for gross motor development (balls, outdoor play equipment)

___ Materials for fine motor development (crayons, cars, blocks, modeling clay)

___ Self help materials (dolls, clothes, house play materials)

___ Visual materials (books, etc.)

5. Special Equipment for Handicapped Children *(Check all that apply)*

___ Special chairs, beds, wheelchairs, or other furniture

___ Special toys or equipment to develop fine or gross motor skills (other than those items recorded in #4)

___ Special audiovisual aids for the handicapped

___ Special books, charts, or other instructional materials

___ Special instructional materials for parents of handicapped children

___ Other ______________________________

Specify: ______________________________

____

6. Are there rooms other than the classroom that are used for implementing the education curriculum (i.e. therapy rooms, gross motor development rooms, etc.)

2 No

58

1 Yes

→ (Please specify) ______________________________

____

____

____

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EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I

IN-DEPTH CHILD CASE STUDY SCHEDULE

1. Grantee ______________________________

2. Delegate Agency ______________________________

Respondents (*Circle if present for any part of interview*)

1 Head Start director/program coordinator
2 Teacher(s)
3 Classroom aide
4 Social worker/parent involvement worker
5 Parents
6 Other (*specify position/function*) ____________________

CARD COLUMN	
	Program Code:
1-5	☐☐☐☐☐
	Child Code:
6-10	☐☐☐☐☐
	Center Code:
11-13	☐☐☐
	Form Number:
14-15	0 [illegible]

Interview Date: __/__/__

Interviewer: ____________________

____

INTERVIEWER: *Before initiating interview, be certain that a parental release form for the interview exists in program records. If such a release is not available, do not procede with interview until such a release has been obtained.*

____GOOD (MORNING, AFTERNOON), MY NAME IS ______________, AND I REPRESENT APPLIED MANAGEMENT SCIENCES OF SILVER SPRING, MARYLAND. WE'RE UNDER CONTRACT TO THE OFFICE OF CHILD DEVELOPMENT TO REVIEW EFFORTS BEING MADE BY HEAD START PROGRAMS ON BEHALF OF HANDICAPPED CHILDREN. AS I'M SURE YOU'RE AWARE, PART OF OUR STUDY REQUIRES THAT WE INTERVIEW HEAD START STAFF ABOUT SPECIFIC HANDICAPPED CHILDREN SO THAT WE MAY GET AN IN-DEPTH PICTURE OF HOW THIS CHILD CAME TO BE ENROLLED IN HEAD START AND WHAT KINDS OF SERVICES ARE BEING PROVIDED TO THIS CHILD. ______________(CHILD'S NAME) WAS ONE OF THE CHILDREN RANDOMLY SELECTED FOR THIS PURPOSE. PLEASE REALIZE THAT IN ANALYZING THE INFORMATION WE WOULD LIKE TO HAVE, ______________(CHILD'S NAME) WILL NEVER BE SINGLED OUT INDIVIDUALLY NOR WILL ANY ONE BE ABLE TO SEPARATE (HIS/HER) DATA FROM THAT OF OTHER CHILDREN IN OUR STUDY. FURTHERMORE, NO ANALYSES WILL BE PROGRAM SPECIFIC. THIS MEANS YOUR PARTICULAR PROGRAM WILL ALSO REMAIN ANONYMOUS. THIS STUDY IS NOT INTENDED TO BE A COMPLIANCE EVALUATION.

WE APPRECIATE YOUR TIME AND COOPERATION IN THIS STUDY. PLEASE FEEL FREE TO ELABORATE ON ANY QUESTION YOU FEEL DOES NOT TRULY INDICATE WHAT HAS HAPPENED DURING ______________'S (CHILD'S NAME) STAY IN YOUR PROGRAM. BE AS OPEN AND AS HONEST AS YOU CAN WITH YOUR ANSWERS.

ARE THERE ANY QUESTIONS?

LET'S BEGIN.

16-17 = "01"

18-19 1. WHAT IS THIS CHILD'S PRIMARY HANDICAPPING CONDITION? *(Circle one)*

1 visually impaired

2 blind

3 hearing impaired

4 deaf

5 physical handicap

6 speech impaired

7 health or developmentally impaired

8 mentally retarded

9 specific learning disability

10 serious emotional disturbance

20 2. WHAT IS THE SEVERITY OF THIS CHILD'S PRIMARY HANDICAP? *(Circle one)*

1 mild

2 moderate

3 severe

4 profound

5 not relevant *(deaf and blind only)*

(Interviewer: Be sure to show criteria cards to indicate the way in which these categories are defined for the handicap identified in #1)

3. WHEN WAS THIS CHILD FIRST ENROLLED IN HIS/HER CURRENT PROGRAM?

21-26 ☐☐ ☐☐ ☐☐
YR MO DAY

4. PLEASE INDICATE THE PROGRAM OPTIONS THAT WERE AVAILABLE TO THIS CHILD UPON HIS/HER ENROLLMENT INTO THIS PROGRAM. *(Check all that apply)*

27 ___ 5 days a week, center based full time *(Standard Head Start Model)* (10)

28 ___ 4 days a week, full time (21)

29 ___ split sessions (22)

30 ___ other variations in center-based attendance (23)

31 ___ double sessions *(part day)* 5 days a week (31)

32 ___ double sessions *(part day)* less than 5 days a week (32)

33 ___ home based, no center attendance (41)

34 ___ home based, center attendance, 1-2 times weekly (42)

35 ___ home based, other regular schedule for center attendance (43)

36 ___ home based, variable center attendance *(including special activities)* (44)

37 ___ locally-designed options *(must have center attendance, otherwise code as 41)*(50)

4a. *(If more than one option is indicated above)*
OF THESE PROGRAM OPTIONS, IN WHICH IS THIS CHILD CURRENTLY ENROLLED? *(insert appropriate code numbers)*

38-39 ☐☐

5. WHAT TYPES OF MAINSTREAMING ARE AVAILABLE TO THIS CHILD THROUGH YOUR PROGRAM? *(Hand respondent list of alternatives. Have him/her select all that are offered) (Check all that apply)*

40 ___ complete mainstreaming of handicapped child into a regular classroom (1) *(no supportive assistance)*

41 ___ complete mainstreaming of handicapped child into a regular classroom (2) with supportive assistances provided by a specialist

42 ___ complete mainstreaming of handicapped children in a classroom where (3) the regular classroom teacher and a special education teacher cooperatively work with all children *(a team arrangement)*

43 ___ reverse mainstreaming in which normal children become part of a (4) special education class

44 ___ partial mainstreaming where handicapped children are in a special (5) education class but go to mainstreamed classes for one or more regular classroom activities

45 ___ handicapped children receive services from your program but are (6) not mainstreamed

5a. *(If more than one option is indicated in #5)*
IN WHICH OF THESE OPTIONS HAVE YOU PLACED THIS CHILD?

46 ☐ *(enter code from #5)*

5b. HOW MUCH TIME WOULD YOU ESTIMATE THAT THIS CHILD SPENDS IN A MAINSTREAM SITUATION WITH NORMAL HEAD START CLASSMATES?

47-48 ☐☐ *(express as a percentage of time spent in Head Start each week)*

6. WHY WAS THE DECISION MADE TO PLACE THIS CHILD IN HIS/HER CURRENT CLASSROOM? *(Indicate only the primary reason)*

49
1 nearest Head Start classroom to child's residence
2 classroom had special staff/facilities for the handicapped
3 classroom had special staff/facilities for this child's particular handicap
4 only classroom with openings available

7. WAS HEAD START THE ONLY EDUCATIONAL/DEVELOPMENTAL PLACEMENT AVAILABLE TO THIS CHILD IN THIS COMMUNITY?

50
2 no
1 yes

7a. WAS THERE AGREEMENT AMONG HEAD START PERSONNEL, THE CHILD'S PARENTS, AND THE CHILD'S DIAGNOSTICIANS ON HIS/HER PLACEMENT IN HEAD START RELATIVE TO OTHER AVAILABLE PROGRAMS?

51
1 yes
2 no

7b. ↳ WHY NOT? (*Place an X in boxes for all that apply*)

	PARENTS	HEAD START PERSONNEL	DIAGNOSTICIANS	OTHERS	
52,53,54,55	☐	☐	☐	☐	Head Start program not equipped to deal with this child's handicap (*staff, facilities*)
56,57,58,59	☐	☐	☐	☐	alternative program perceived as better able to provide services to this child (*staff, facilities*)
60,61,62,63	☐	☐	☐	☐	mainstreaming not considered appropriate for this child
64,65,66,67	☐	☐	☐	☐	other (*specify all that apply*) ________________ ________________

16,17 = "02"

8. PLEASE GIVE THE FOLLOWING INFORMATION ON THE CLASSROOM IN WHICH THE CHILD HAS BEEN PLACED.

18-19	☐☐	number of children in child's classroom
20-21	☐☐	number of handicapped children in child's classroom
22-23	☐☐	number of teachers having instructional responsibility in this child's class (*does not include substitutes*)
24-25	☐☐	number of other adults typically in the classroom
26-27	☐☐	handicapped/non-handicapped ratio (*computed by interviewer*)
28-29	☐☐	teacher/pupil ratio (*computed by interviewer*)
30-31	☐☐	adult/child ratio (*computed by interviewer*)

9. PLEASE INDICATE QUALIFICATIONS OF EXISTING CLASSROOM STAFF FOR THIS CHILD. *(Enter number in each category)*

		EDUCATION	TEACHER	AIDES	EDUCATIONAL COORDINATOR
32[illegible]3,34-35,36-37	a.	less than high school	☐☐	☐☐	☐☐
38-39,40-41,42-43	b.	high school graduate	☐☐	☐☐	☐☐
44[illegible]5,46-47,48-49	c.	associate degree/some college but no B.A./B.S.	☐☐	☐☐	☐☐
50[illegible]1,52-53,54-55	d.	college graduate	☐☐	☐☐	☐☐
56[illegible]7,58-59,60-61	e.	postgraduate education *(degreed or otherwise)*	☐☐	☐☐	☐☐
	9a.	DEGREE AREA			
62-63,64-65,66-67	a.	degree in special education	☐☐	☐☐	☐☐
68[illegible]9,70-71,72-73	b.	degree in early childhood development	☐☐	☐☐	☐☐
74-75,76-77,78-79	c.	other degree area	☐☐	☐☐	☐☐
1[illegible]17 = "03"	9b.	CERTIFICATION			
18-19,20-21,22-23	a.	State certified for special education	☐☐	☐☐	☐☐
24-25,26-27,28-29	b.	Child Development Associate *(credentialed)*	☐☐	☐☐	☐☐
30[illegible]1,32-33,34-35	c.	Child Development Associate *(participating)*	☐☐	☐☐	☐☐
36[illegible]7,38-39,40-41	d.	other *(specify)* ______________ ______________	☐☐	☐☐	☐☐

10. IS CERTIFICATION REQUIRED IN THIS STATE FOR TEACHERS WORKING WITH HANDICAPPED PRESCHOOLERS?

42
2 no
1 yes

→ 10a. DO THESE CERTIFICATION REQUIREMENTS PERTAIN TO THE AGE AND HANDICAPPING CONDITION OF THIS CHILD?

43
2 no
1 yes

11. WHAT TYPES OF IN-SERVICE TRAINING HAS YOUR CLASSROOM STAFF RECEIVED RELATING TO HANDICAPPED CHILDREN? *(Interviewer, only major programs, if more than 5 are provided)*

	TYPE OF TRAINING	PROVIDER	HOURS OF TRAINING	RECIPIENTS
44-45,46-47,48-49,50,51,52	☐☐	☐☐	☐☐	☐ ☐ ☐
53-54,55-56,57-58,59,60,61	☐☐	☐☐	☐☐	☐ ☐ ☐
62-63,64-65,66-67,68,69,70	☐☐	☐☐	☐☐	☐ ☐ ☐
71-72,73-74,75-76,77,78,79	☐☐	☐☐	☐☐	☐ ☐ ☐
16-17 = "04" 18-19,20-21,22-23,24,25,26	☐☐	☐☐	☐☐	☐ ☐ ☐

(Interviewer: Codes for #11)

TRAINING TYPE

1 *knowledge of Head Start performance standards*
2 *behavior modification/classroom management*
3 *individualized instructional techniques*
4 *preparation of individual learning objectives*
5 *working with parents*
6 *strategies for recruitment of handicapped children*
7 *screening and assessment*
8 *theory and practice of mainstreaming*
9 *specific training for this child's handicap (e.g., blind, deaf, etc.)*
10 *understanding handicapping conditions*
11 *other (specify)* ______________________

RECIPIENT

1 *teacher*
2 *aide*
3 *other*

PROVIDER

1 *Resource Access Program (RAP)*
2 *Head Start personnel*
3 *public school system*
4 *university/college*
5 *private clinician/consultant*
6 *public health department*
7 *BEH First Chance or other BEH training project*
8 *University Affiliated Facility (UAF)*
9 *private organization (e.g., Easter Seal)*
10 *other (specify)* ______________________

12. IS THERE ADDITIONAL TRAINING THAT WOULD ALLOW YOU AND YOUR STAFF TO BETTER MEET THE NEEDS OF THIS CHILD? *(Interviewer: Please have respondent prioritize these needs with "1" = highest priority, "2" = next highest priority, "12" = lowest priority, etc.; ties are not allowed and each box need not be filled in)*

27-28 ☐☐ no additional training is required

29-30 ☐☐ knowledge of Head Start performance standards

31-32 ☐☐ behavior modification/classroom management

33-34 ☐☐ individualized instructional techniques

35-36 ☐☐ preparation of individual learning objectives

37-38 ☐☐ working with parents

39-40 ☐☐ strategies for recruitment of handicapped children

41-42 ☐☐ screening and assessment

43-44 ☐☐ theory and practice of mainstreaming

45-46 ☐☐ working with this child's handicap

47-48 ☐☐ understanding handicapping conditions

49-50 ☐☐ other *(specify)* ______________________________

NOW WE'D LIKE TO ASK YOU A FEW QUESTIONS ABOUT THE WAY IN WHICH THIS CHILD CAME TO THE ATTENTION OF YOUR PROGRAM.

13. THIS CHILD WAS: (*Circle one*)

51
1 referred to Head Start by outside agency, but not because of handicap
2 referred to Head Start by outside agency because of handicap
3 enrolled as a result of normal recruitment/child find activities
4 enrolled as a result of special child find/recruitment efforts
5 parent referred/other siblings previously in Head Start

→ 13a. ARE THESE OUTSIDE AGENCIES A PART OF YOUR USUAL RECRUITMENT/CHILD FIND NETWORK?

52
2 no
1 yes

13b. PLEASE INDICATE THE PROFESSIONAL RESPONSIBLE FOR THIS CHILD'S REFERRAL AND THE AGENCY WITH WHICH THIS INDIVIDUAL IS ASSOCIATED (*Circle one from each list*)

53,54-55

PROFESSIONAL

1 psychologist/psychiatrist
2 pediatrician/other medical personnel
3 speech therapist/audiologist
4 paraprofessional medical personnel
5 social worker
6 public health nurse
7 interdisciplinary team
8 other (*specify*) ______________

AGENCY

1 private practitioner/consultant
2 hospital (*public*)
3 public or State health department
4 social services department (*Local or State agency*)
5 public school system
6 Easter Seal Agency
7 Crippled Children Association
8 Association for Retarded Children
9 BEH First Chance Project
10 Universtiy Affiliated Facilities (UAF)
11 other (*specify*) ______________

14. WHEN WAS SCREENING COMPLETED FOR THIS CHILD?

56
1 prior to enrollment
2 after enrollment

57-62
→ ☐☐ ☐☐ ☐☐
YR MO DAY

63 15. WHAT SCREENING SERVICES WERE PROVIDED FOR THIS CHILD? *(Circle one)*

1 complete screening as specified under Head Start performance standards

2 complete screening as specified under Head Start performance standards plus additional screening services

15a. PLEASE INDICATE 1) WHO PROVIDED SCREENING SERVICES IN EACH OF THE FOLLOWING AREAS, 2) THE AGENCY(S) WITH WHICH THE PROVIDERS(S) IS/ARE ASSOCIATED, 3) WHAT SCREENING TECHNIQUES WERE UTILIZED, AND 4) WHO PAID FOR THESE SERVICES. *(For those screening services provided, fill in boxes to the right with appropriate codes from page 9)*

	SCREENING SERVICES		PROVIDER	AGENCY	TECHNIQUE*	FUNDING	DATE COMPLETED YR	MO	DAY
6[illegible]5-66,67,68,69-74	vision	regular	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
16-17 = "05"									
18,19-20,21,22,23-28		additional	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
29[illegible]0-31,32,33,34-39	hearing	regular	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
40,41-42,43,44,45-50		additional	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
51,52-53,54,55,56-61	physical coordination & development	regular	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
62,63-64,65,66,67-72		additional	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
16-17 = "06"									
1[illegible]9-20,21,22,23-28	speech and language	regular	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
29[illegible]0-31,32,33,34-39		additional	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
40,41-42,43,44,45-50	intellectual development	regular	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
51[illegible]2-5[illegible],54,55,56-61		additional	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
62[illegible]3-64,65,66,67-72	social/emotional development	regular	☐	☐☐	☐	☐	☐☐	☐☐	☐☐
16-17 = "07"									
1[illegible]9-20,21,22,23-28		additional	☐	☐☐	☐	☐	☐☐	☐☐	☐☐

*(Interviewer: Leave this column blank. List techniques on page 9)

16. WHY DID YOU USE THE SCREENING SERVICES OF THE ABOVE-NAMED PROFESSIONAL/AGENCIES? *(Place reason codes in box next to screening area)*

29	vision	regular	☐
30		additional	☐
31	hearing	regular	☐
32		additional	☐
33	physical coordination and development	regular	☐
34		additional	☐
35	speech and language	regular	☐
36		additional	☐
37	intellectual development	regular	☐
38		additional	☐
39	social/emotional development	regular	☐
40		additional	☐

REASON CODES	
1	least expensive service available
2	best service available
3	only available service
4	part of established screening service with which program is associated *(public school, EPSDT, etc.)*
5	agency used particularly for this child; screening not generally provided to all Head Start enrollees
6	no choice in the matter - child was screened prior to referral *(other than #4)*

17. IN WHICH OF THE FOLLOWING AREAS DID SCREENING RESULTS INDICATE A POTENTIAL HANDICAP? *(Check all that apply)*

41 ___ vision
42 ___ hearing
43 ___ physical coordination and development
44 ___ intellectual development
45 ___ speech and language
46 ___ social/emotional development

DEVELOPMENT OF THE DIAGNOSTIC FILE

NOW THAT WE HAVE DISCUSSED THE MANNER IN WHICH THIS CHILD WAS SCREENED FOR POTENTIAL HANDICAPS, LET'S TALK ABOUT THE DEVELOPMENT OF THIS CHILD'S DIAGNOSTIC FILE. WHEN WE REFER TO A DIAGNOSTIC FILE, WE REFER TO THOSE DOCUMENTS, REPORTS, TESTS AND OBSERVATIONS WHICH 1) CONFIRM THE NATURE OF A CHILD'S HANDICAP (PART A); 2) DESCRIBE WHAT THE CHILD CAN AND CANNOT DO IN THE BASIC DEVELOPMENTAL AREAS (PART B - FUNCTIONAL ASSESSMENT); AND 3) OFFER RECOMMENDATIONS FOR THERAPY, INSTRUCTIONAL INTERVENTION AND SERVICE DELIVERY (PART C - RECOMMENDATIONS). IF THIS CHILD'S DIAGNOSTIC FILE DOES NOT CONTAIN MATERIALS ADDRESSING EACH OF THESE THREE AREAS, DO NOT BE CONCERNED. REMEMBER THE RESULTS OF THIS STUDY WILL BE USED ONLY FOR OCD POLICY FORMATION. TO REPEAT, THIS IS NOT A COMPLIANCE EVALUATION.

18. PLEASE INDICATE FOR EACH OF THE COMPONENTS OF THE DIAGNOSTIC FILE 1) WHO PROVIDED THE DIAGNOSTIC SERVICE, 2) THE AGENCY WITH WHICH THE PROVIDER(S) WAS ASSOCIATED, AND 3) WHAT METHODS OR TECHNIQUES WERE UTILIZED. ADDITIONALLY WE WOULD LIKE TO KNOW WHO PAID FOR THESE SERVICES, WHERE SUCH INFORMATION IS APPROPRIATE.

	DIAGNOSTIC AREA	9 PROVIDER	12 AGENCY	9 TECHNIQUE	10 FUNDING	DATE COMPLETED YR	 MO	 DAY
47[illegible]8-49,50-51,52-53,54-59	vision-confirmation	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
60,61-62,63-64,65-66,67-72	assessment	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
16-17 = "08"								
18[illegible]9-20,21-22,23-24,25-30	recommendations	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
31,32-33,34-35,36-37,38-43	hearing-confirmation	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
44[illegible]5-46,47-48,49-50,51-56	assessment	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
57[illegible]8-59,60-61,62-63,64-69	recommendations	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
16-17 = "09"	physical coordination & development							
18[illegible]9-20,21-22,23-24,25-30	confirmation	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
31,32-33,34-35,36-37,38-43	assessment	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
44[illegible]5-46,47-48,49-50,51-56	recommendations	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
	intellectual development							
57[illegible]8-59,60-61,62-63,64-69	confirmation	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
16-17 = "10"								
18,19-20,21-22,23-24,25-30	assessment	☐	☐☐	☐8	☐☐	☐☐	☐☐	☐☐
31[illegible]2-33,34-35,36-37,38-43	recommendations	☐	☐☐	☐4	☐☐	☐☐	☐☐	☐☐
	speech and language							
44,45-46,47-48,49-50,51-56	confirmation	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
57[illegible]8-59,60-61,62-63,64-69	assessment	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
16-17 = "11"								
18,19-20,21-22,23-24,25-30	recommendations	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
	social/emotional development							
31,32-33,34-35,36-37,38-43	confirmation	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
44[illegible]5-46,47-48,49-50,51-56	assessment	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
57[illegible]8-59,60-61,62-63,64-69	recommendations	☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
16-17 = "12"								

19. IN WHICH OF THE FOLLOWING AREAS DID DIAGNOSTIC EFFORTS REVEAL A CONFIRMED HANDICAP? *(Check all that apply)*

18 ___ blindness (1)
19 ___ visual impairment (2)
20 ___ deafness (3)
21 ___ hearing impaired (4)
22 ___ physical handicap (5)
23 ___ speech impairment (6)
24 ___ health or developmental impairment (7)
25 ___ mental retardation (8)
26 ___ specific learning disabilities (9)
27 ___ serious emotion disturbance (10)

20. WERE DIAGNOSTIC SERVICES READILY AVAILABLE TO THIS CHILD? *(Insert reason code for each area)*

28 vision-confirmation ☐
29 assessment ☐
30 recommendations ☐
31 hearing-confirmation ☐
32 assessment ☐
33 recommendations ☐
34 physical coordination-confirmation ☐
35 assessment ☐
36 recommendations ☐
37 intellectual development-confirmation ☐
38 assessment ☐
39 recommendations ☐
40 speech and language-confirmation ☐
41 assessment ☐
42 recommendations ☐
43 social/emotional development-confirmation ☐
44 assessment ☐
45 recommendations ☐

REASONS AND CODES

1 yes

no because *(pick most important)*:

2 professional diagnostician not available
3 lack of money to pay for diagnosis
4 family reluctance to cooperate
5 child was untestable/unmanageable
6 other *(specify)*

____

____

21. CONCERNING THIS CHILD'S DIAGNOSIS, DID YOU ENCOUNTER ANY DIFFICULTIES BECAUSE THE DIAGNOSTICIAN'S DEFINITIONS OF THE VARIOUS HANDICAPPING CONDITIONS DIFFER FROM THOSE DEVELOPED BY HEAD START?

46 2 no

1 yes

→ (*specify handicap; use codes from #19*)

7-48 ☐☐

22. HAVE YOU OR A MEMBER OF YOUR STAFF WHO IS RESPONSIBLE FOR DEVELOPING THIS CHILD'S INDIVIDUAL PLAN OF SERVICES EVER SEEN HIS/HER DIAGNOSTIC FILE? (*Circle one*)

49 1 yes

2 no, not at all

3 no, but the results were given to me by another member of the Head Start staff (*other than to simply confirm child as handicapped*)

4 no, but the results were given to me by the diagnostician (*other than to simply confirm child as handicapped*)

→ 22a. IF YOU HAVE NOT SEEN A COPY OF THE DIAGNOSTIC FILE, WHY NOT? (*Circle one*)

50 1 file maintained in diagnostician's office

2 file maintained at program headquarters, but not at this center

3 as far as is known, it doesn't exist anywhere

4 it's available on site, but the staff has not reviewed it

5 diagnostic files are reviewed by other Head Start staff, although the people involved in planning for this child's services did not see the file

23. WERE THIS CHILD'S PARENTS INCLUDED AS PART OF A DIAGNOSTIC TEAM?

51 2 no

1 yes

24. WERE DIAGNOSTIC RESULTS PRESENTED AND EXPLAINED TO THIS CHILD'S PARENTS? *(Check one)*

52-53 (Check indicates the line to be punched)

___ ☐ 1 ☐ 0 no

___ ☐ 2 ☐ yes, by diagnostician only

___ ☐ 3 ☐ yes, by staff only

___ ☐ 4 ☐ yes, by staff/diagnostician together

24a. HOW WERE THE RESULTS COMMUNICATED? *(Insert appropriate code: written report as "1", verbal report (meeting) as "2", and both as "3" in the boxes next to the method selected)*

25. WHY DID YOU USE THE PARTICULAR DIAGNOSTIC SERVICES PROVIDERS FOR THIS CHILD? *(Please put reason codes in the boxes next to diagnostic areas)*

	DIAGNOSTIC AREA	REASON
54	vision	☐
55	hearing	☐
56	physical development and coordination	☐
57	speech and language	☐
58	intellectual development	☐
59	social/emotional development	☐

	REASON CODES
1	least expensive service available
2	best service available
3	only available service
4	part of established diagnostic service with which your program is associated *(public schools, EPSDT)*
5	no choice in the matter - children are generally diagnosed prior to enrollment *(other than #4)*
6	other *(specify)* ______________________

INDIVIDUAL PLAN OF SERVICES

TO THIS POINT WE'VE DISCUSSED ________________ (CHILD'S NAME) ENTRY INTO YOUR PROGRAM AND THE PROVIDERS USED TO SCREEN FOR AND IDENTIFY HIS/HER SPECIFIC PROBLEMS. WE'D NOW LIKE TO ASK A FEW QUESTIONS ABOUT THE SERVICES ACTUALLY PROVIDED TO THIS CHILD BY YOUR PROGRAM.

26. DOES THIS CHILD HAVE AN INDIVIDUAL PLAN OF SERVICES?

60 2 no *(Go to question #29)*

1 yes

26a. IS THIS A WRITTEN PLAN?

61 2 no

1 yes *(If yes, obtain a copy)*

26b. DOES THIS PLAN INCLUDE AN INDIVIDUALIZED EDUCATIONAL PLAN?

62 2 no

1 yes *(If yes, obtain copy. Presumably this will be included with the Individual Plan of Services)*

27. DID YOU USE THIS CHILD'S DIAGNOSTIC FILE IN DEVELOPING THIS SERVICE PLAN? *(Circle one)*

63 1 not at all

2 used the diagnostic file, but only to a slight degree

3 used the diagnostic file extensively

28. WHAT PARTICULAR PROBLEM DID YOU HAVE IN USING THE DIAGNOSTIC FILE TO DEVELOP THE INDIVIDUAL PLAN OF SERVICES? *(Circle one)*

64 1 no problems *(used diagnostic report extensively)*

2 no problems, but other sources of information were more useful for planning purposes

3 diagnosis was outdated *(no longer accurate)*

4 didn't receive report in time for planning purposes

5 terminology was too technical

6 diagnostician and Head Start staff disagreed as to what services were required on the basis of the diagnostic report

7 couldn't obtain copy of the file

8 diagnostic file too general for planning purposes

9 other ______________________________ *(specify)*

LET'S DISCUSS SPECIFIC ACTIVITIES THAT YOU MAY HAVE PLANNED FOR ________ (CHILD'S NAME) DURING HIS/HER ENROLLMENT IN YOUR PROGRAM. IF YOU HAVE ANY QUESTIONS ABOUT DEFINITIONS OF THE ACTIVITY AREAS INDICATED, PLEASE FEEL FREE TO ASK FOR CLARIFICATION.

29. PLEASE INDICATE IF YOU HAVE PLANNED OBJECTIVES FOR THIS CHILD IN EACH OF THE FOLLOWING ACTIVITY AREAS. THEN INDICATE THE CONTEXT FOR WHICH THESE PLANS HAVE BEEN DEVELOPED (*Lesson, activities, etc.*). (*Circle codes that apply - one for each area. If no objectives in a given area, then leave blank*)

		Method of Implementation			
	Objective Area	Planned for all children the same way	Planned for all children but modified for this child	Planned because of this child's handicapping condition but not planned for all children	Not planned for this child because of handicap but planned for other children
65	cognitive	1	2	3	4
66	communication skills	1	2	3	4
67	self-help	1	2	3	4
68	self-concept	1	2	3	4
69	gross motor	1	2	3	4
70	fine motor	1	2	3	4
71	other __________ __________ (*specify*)	1	2	3	4

16-17 = "13"

NOW LET'S DISCUSS THE SPECIFIC ACTIVITIES THAT YOU ACTUALLY CONDUCT FOR THIS CHILD. THAT IS, THE PREVIOUS QUESTION ADDRESSED YOUR PLANS. THIS QUESTION ADDRESSES THE WAY IN WHICH THESE PLANS ARE USUALLY IMPLEMENTED.

30. PLEASE INDICATE THE WAY IN WHICH LESSONS AND ACTIVITIES ARE USUALLY CONDUCTED FOR THIS CHILD IN EACH OF THE FOLLOWING OBJECTIVE AREAS. (*Coding procedures are the same as for #29*)

	Objective Area	Conducted for all children the same way	Conducted for all handicapped children the same way	Specifically conducted for this child	Not conducted for this child because of handicap, but done for other children
18	cognitive	1	2	3	4
19	communication skills	1	2	3	4
20	self-help	1	2	3	4
21	self-concept	1	2	3	4
22	gross motor	1	2	3	4
23	fine motor	1	2	3	4
24	other __________ __________ (*specify*)	1	2	3	4

31. DO YOU USE SPECIFIC WRITTEN CURRICULA FOR ANY OF THE ABOVE-REFERENCED OBJECTIVE AREAS?

25

2 no

1 yes

→ 31a. PLEASE SPECIFY THE TYPE OF CURRICULUM BY OBJECTIVE AREA, WHETHER YOU USE IT AS ORIGINALLY DEVELOPED OR MODIFIED, AND WHETHER THE MATERIALS ARE PERFORMANCE BASED OR EXPERIENCED BASED.

(Interviewer: Take time to elaborate on this request. First, ask for curricula actually used and then check these materials against each objective area)

	OBJECTIVE AREA	CURRICULUM*	ADAPTED	FORMAL/ INFORMAL	PERFORMANCE/ EXPERIENCE	GENERAL/SPECIAL FOR HANDICAPPED
26 7,28,29,30	____ cognitive	☐	☐	☐	☐	☐
31,32,33,34,35	communication skills	☐	☐	☐	☐	☐
36 7,38,39,40	self-help	☐	☐	☐	☐	☐
41,42,43,44,45	self-concept	☐	☐	☐	☐	☐
46 7,48,49,50	gross motor	☐	☐	☐	☐	☐
51,52,53,54,55	fine motor	☐	☐	☐	☐	☐
56 7,58,59,60	other *(specify)* ____________ ____________	☐	☐	☐	☐	☐

**(Interviewer: Leave this column blank. Complete blank below)*

(Interviewer: Codes for 31a)

CURRICULUM

1 *locally designed materials*
2 *(specify)* ____________
3 *(specify)* ____________
4 *(specify)* ____________
5 *(specify)* ____________
6 *(specify)* ____________
(these titles will be coded at later date)

GENERAL CURRICULUM OR SPECIAL HANDICAPPED

1 *used for all children*
2 *used for all handicapped*
3 *used specifically for special children*
4 *other (specify)* ____________

ADAPTED

1 *adapted*
2 *used as written*
3 *other (specify)* ____________

PERFORMANCED BASED/EXPERIENCED BASED

1 *performance based*
2 *experienced based*
3 *mixed*
4 *unknown*
5 *other (specify)* ____________

FORMAL/INFORMAL

1 *written*
2 *informal; unwritten*
3 *mixed*

32. DO YOU REGULARLY MONITOR THIS CHILD'S PROGRESS AGAINST THE OBJECTIVES YOU'VE ESTABLISHED?

2 no
61 1 yes

→32a. HOW IS THIS MONITORING ACCOMPLISHED? (*Insert codes for all that apply*)

HOW OFTEN? (*Mark appropriate code*)

62 formal (*standardized*) tests ☐
63 assessments that are part of a specific curriculum package ☐
64 teacher/center designed assessment ☐
65 unstructured observation ☐
66 parent report ☐
67 other ______________ (*specify*) ☐

(*Interviewer:* *Codes for 32a.*)

1 weekly
2 monthly
3 twice a year
4 yearly
5 other _____ (specify)

32b. HAVE YOU EVER CHANGED THIS CHILD'S INDIVIDUAL PLAN OF SERVICES BASED ON THE RESULTS OF THIS MONITORING?

1 yes
68 2 no

69

16-17 = "14"

33. DO YOU UTILIZE THE SERVICES OF PROFESSIONAL SPECIALISTS IN PROVIDING SERVICES FOR YOUR HANDICAPPED CHILDREN?

2 no

1 yes

→ 33a. PLEASE INDICATE THE SPECIALISTS USED AND THEIR CONTRIBUTION TO YOUR PROGRAM OF ACTIVITIES (*including frequency of services provided*)

		Professional (*Check all that apply*)	INVOLVEMENT AREA (*place X in appropriate boxes*) Works with child at another site	Works with child in the classroom	Trains/consults with teacher	Trains parents	Evaluates child's progress	Observes in classroom	Other (*specify*)	HOW MUCH TIME IS SPENT WITH THIS CHILD (*Circle one*) Weekly	Monthly	1-4 times a year	Other (*specify*)
18, 9,20,21,22.23.24,25,26	___	physician	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
27,28,29,30,31,32,33,34,35	___	nurse	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
36, ,38,39,40,41,42,43,44	___	psychologist/ psychiatrist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
45, 6,47,48,49,50,51,52,53	___	speech pathologist/ therapist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
54,55,56,57,58,59,60,61,62	___	social worker	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
63, 4,65,66,67,68,69,70,71	___	nutritionist/ dietician	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
16-17 = "15" 3369 18,19,20,21,22.23.24,25,26	___	certified special education teacher	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
27, ,29,30,31,32,33,34,35	___	physical therapist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
36,37,38,39,40,41,42,43,44	___	occupational therapist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
45,46,47.48.49.50.51,52,53	___	ophthamologist/ optometrist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4
54, 5,56,57,58,59,60,61,62	___	other specialist (*specify*) ________________ ________________	☐	☐	☐	☐	☐	☐	☐	1	2	3	4

34. IS THIS CHILD RECEIVING SERVICES AS A PART OF HIS/HER WEEKLY SCHEDULE FROM AN AGENCY OTHER THAN HEAD START?

(Interviewer: Elaborate as to the kinds of services of interest, see below)

A 63
2 no
1 yes

→ 34a. WHAT KINDS OF SERVICES ARE PROVIDED, WHAT TYPE OF AGENCY PROVIDES THEM, HOW WAS/IS HEAD START INVOLVED IN THE PROVISION OF THESE SERVICES, AND WHO PAYS FOR THEM? *(Enter code only if service is being provided)*
(Interviewer: This is a complex question. Repeat it as often as necessary to get the information required. Begin by reading the list of potential services. Codes for responses are indicated on page 22)

	SERVICE	PRIMARY PROVIDER	ROLE OF HEAD START	WHO PAYS?
64-65,66,67	day care	☐☐	☐	☐
68-69,70,71	educational instruction	☐☐	☐	☐
72-73,74,75 3	family counseling	☐☐	☐	☐
76-77,78,79	medical/dental treatment	☐☐	☐	☐
16-17 = "16" 18-19,20,21/E	occupational/physical therapy	☐☐	☐	☐
22-23,24,25	other therapy related to child's handicap	☐☐	☐	☐
26-27,28,29	other *(specify)* ____________	☐☐	☐	☐

____

35. ARE THERE ANY OTHER SPECIAL SERVICES THAT YOUR PROGRAM PROVIDES THIS CHILD THAT ARE DONE SPECIFICALLY BECAUSE OF HIS/HER HANDICAP THAT WE HAVE NOT YET DISCUSSED?

2 no

30

1 yes

→ Please describe these services

31 ☐ ______________________________

32 ☐ ______________________________

33 ☐ ______________________________

34 ☐ ______________________________

35 ☐ ______________________________

36 ☐ ______________________________

37 ☐ ______________________________

(Interviewer: Leave boxes blank. Record respondent's answers verbatim. Answers will be coded at the conclusion of field activities)

Please be certain that the respondent considers this question carefully. We are interested in such services as securing and training the use of prosthetic devices, specialized educational materials acquired specifically for this child, special modification of program facilities for this child, etc. Probe in depth to determine what is actually being done for this child not covered elsewhere in this schedule.

(22)

FINALLY WE'D LIKE TO DISCUSS THE WAYS IN WHICH THIS CHILD'S PARENTS ARE INVOLVED IN YOUR PROGRAM.

36. HOW WOULD YOU CHARACTERIZE THE INVOLVEMENT OF THIS CHILD'S PARENTS IN YOUR PROGRAM?

38 1 very active
2 average involvement
3 only minor involvement
4 do not participate at all

37. PLEASE INDICATE THE WAYS IN WHICH THIS CHILD'S PARENTS WERE/ARE INVOLVED IN THE DEVELOPMENT/IMPLEMENTATION OF THE INDIVIDUAL PLAN OF SERVICES. *(Check all that apply)*

39 ___ no involvement
40 ___ parent teaches child at home using performance based criteria
41 ___ parent teaches child at home using experience based criteria
42 ___ parent informed of the progress of the child in the classroom
43 ___ parent involved in classroom activities with the child
44 ___ parent aids in the evaluation of child's progress
45 ___ parent designs activities for class or home
46 ___ parent approves individual plan
47 ___ parent helps design individual plan
48 ___ other ________________________________ *(specify)*

38. PLEASE INDICATE THE WAYS IN WHICH THIS CHILD'S PARENTS ARE INVOLVED IN YOUR GENERAL PROGRAM ACTIVITIES. *(Check all that apply)*

49 ___ no involvement
50 ___ parent provides transportation for his/her child or other children
51 ___ parent trains or counsels other parents (i.e., a parent trained in a skill shares that skill with other parents)
52 ___ parent is involved in outreach and recruitment of other handicapped children
53 ___ parent involved in developing a community resource file
54 ___ parent helped develop objectives for social services and parent involvement activities
55 ___ parent functions as a liaison between Head Start and non-Head Start agency(s
56 ___ parent contributed by making or donating materials for the classroom
57 ___ parent involved in functions with parents of other normal Head Start children (social functions, class functions, etc.)
58 ___ other ________________________________ *(specify)*

39. IN WHICH OF THE FOLLOWING AREAS DID THIS CHILD'S PARENTS RECEIVE SPECIFIC TRAINING AND WHO PROVIDED THIS TRAINING? *(Check all that apply)*

		PROVIDERS			
	TRAINING AREA	REGIONAL/STATE HEAD START STAFF	LOCAL HEAD START STAFF	OTHER PROFESSIONALS	OTHER *(specify)*
59,60,61,62	assessment	☐	☐	☐	☐ ______
63,64,65,66	program goals and objectives	☐	☐	☐	☐ ______
67,68,69,70	normal child growth and development	☐	☐	☐	☐ ______
71,72,73,74	identifying special needs of their child	☐	☐	☐	☐ ______
75,76,77,78 16-17 = 1	educational planning	☐	☐	☐	☐ ______
18,19,20,21	availability of other community resources	☐	☐	☐	☐ ______
22,23,24,25	legal rights related to their child	☐	☐	☐	☐ ______
26,27,28,29	genetic counseling	☐	☐	☐	☐ ______
30,31,32,33	emergency first aid	☐	☐	☐	☐ ______
34,35,36,37	information concerning their child's specific handicap	☐	☐	☐	☐ ______
38,39,40,41	other *(specify)* ______________	☐	☐	☐	☐ ______

40. ARE THERE ANY SERVICES YOU WOULD LIKE TO MAKE AVAILABLE EITHER TO THIS CHILD OR HIS/HER FAMILY THAT YOU HAVE NOT HAD THE RESOURCES AND/OR THE TIME TO PROVIDED?

42
2 no
1 yes
→ 40a. WHAT SERVICES? *(Interviewer: Coding will be done at later date. Enter responses verbatim)*

43 ☐ ______________________________
44 ☐ ______________________________
45 ☐ ______________________________
46 ☐ ______________________________

OMB # 85-S77002
EXPIRES 12/31/77

EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I
FACILITIES WALK-THROUGH CHECKLIST - SECTION B

1. Grantee: ____________________

2. Delegate Agency: ____________________

CA[illegible] COLUMN

Program Code: ☐☐☐☐☐ 1-5

Program Name: ____________________

Child Code ☐☐☐☐☐ 6[illegible]0

Center Code ☐☐☐ 11[illegible]3

Form Number 0 5 14,15

F

Interviewer: ____________________

Walk-through Date: __/__/__

FACILITIES WALK-THROUGH CHECKLIST

SECTION B

INTERVIEWER:

THIS DOCUMENT SHOULD BE COMPLETED FOR EACH CHILD SELECTED FOR IN-DEPTH CASE STUDY. YOU ARE NOT EXPECTED TO COMPLETE THIS DOCUMENT FOR ALTERNATE (NON-HEAD START) PROGRAMS. TO COMPLETE THIS FORM YOU WILL NEED TO OBSERVE THE CHILD WHO IS THE SUBJECT OF THIS DOCUMENT IN THE CLASSROOM. YOU ARE REQUIRED TO OBSERVE THIS CHILD FOR A MINIMUM OF 15 MINUTES. IF IT IS POSSIBLE CONSIDERING YOUR TIME CONSTRAINTS ON SITE, AN OBSERVATION OR OBSERVATIONS ADDING TO ONE HOUR IS HIGHLY DESIRABLE.

PRIOR TO INITIATING YOUR OBSERVATION OF THE CHILD IN THE CLASSROOM OBTAIN PERMISSION FROM THE HEAD START STAFF. IF PERMISSION IS NOT GRANTED, DO NOT INSIST UPON YOUR REQUEST.

IF PERMISSION IS GRANTED, TRY TO CONDUCT YOUR OBSERVATION AS UNOBTRUSIVELY AS POSSIBLE. YOUR DEMEANOR SHOULD BE THAT OF LEARNING ABOUT, NOT JUDGING, THE CLASSROOM ACTIVITIES. IF YOU WISH TO ASK THE TEACHER ABOUT WHAT YOU OBSERVED WAIT UNTIL SHE IS FREED FROM HER CLASSROOM RESPONSIBILITIES. IT IS NOT ANTICIPATED THAT YOU WILL NEED TO TALK TO THE TEACHER TO COMPLETE THIS DOCUMENT.

FACILITIES WALK THROUGH
SECTION B

CLASSROOM OBSERVATION

6-="01" 1. What number of adults were present in the classroom?

18-19 ☐☐ number of adults in classroom

2. What number of children were present in the classroom?

0-21 ☐☐ number of children in classroom

3. What number of children were observably handicapped in the classroom?

-23 ☐☐ number of observably handicapped children in classroom

4. Observation Record

Observation #1

-27 ☐☐☐☐ Time that observation in classroom was initiated (to the nearest half-hour).

-29 ☐☐ Duration of observation (to nearest quarter hour).

Observation #2

30-33 ☐☐☐☐ Time that observation in the classroom was initiated (to the nearest half-hour).

-35 ☐☐ Duration of observation (to nearest quarter hour).

Observation #3

36-39 ☐☐☐☐ Time that observation in classroom was initiated (to nearest half-hour).

0-41 ☐☐ Duration of observation (to nearest quarter hour).

5. Director of activities(s) observed *(place an X in boxes for all that apply)*

		Teacher directed	Aide directed	Other	
42,43,44	Observation #1	☐	☐	☐	*(specify)*________________
45,46,47	#2	☐	☐	☐	*(specify)*________________
48,49,50	#3	☐	☐	☐	*(specify)*________________

6. Type of group structure(s) the child was engaged in *(place an X in boxes for all that apply)*

		Individual	Individual with an adult	Small group all handicapped children *(2-4 children)*	Small group with normal children *(2-4 children)*	Large group with all handicapped children *(5 or more children)*	Large group with normal children *(5 or more children)*
51,52,53,54,55,56	Observation #1	☐	☐	☐	☐	☐	☐
57,58,59,60,61,62	#2	☐	☐	☐	☐	☐	☐
63,64,65,66,67,68	#3	☐	☐	☐	☐	☐	☐

7. During your classroom observations, how socially integrated did the subject child seem to be? *(Circle one response)*

69 1 not socially integrated - child was mostly isolated from the group, very few comments made to him or by him to others 5

2 somewhat socially integrated - child was in close proximity to other children but did not seem completly integrated into group interaction

3 socially integrated - could not distinguish this child from other children on the basis of group interaction

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Expires: 12 /31 /77

EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I
WRITTEN RECORD REVIEW

1. Grantee: ______________________
2. Delegate Agency: ______________________

Program Code: ☐☐☐☐☐ 1

Program Name: ______________________

Child Code: ☐☐☐☐☐ 6-10

Center Code: ☐☐☐ 11 3

Interviewer: ______________________

Form Number: 0 6 14 5

G

Date: __/__/__

16-17="01"

WRITTEN RECORDS REVIEW

1. Did you locate a diagnostic file?

13
2 No

1 Yes

Where? ____________________________

2. Did you locate a written individual service plan?

19
2 No

1 Yes

Where? ____________________________

3. Did you locate written reports on monitoring/child progress?

20
2 No

1 Yes

Where? ____________________________

COMMENTS: *(Record here any relevant information if you failed to locate or had difficulty locating any of the above written records)*

A. DIAGNOSTIC FILE REVIEW GUIDE

Confirmation of Handicap:

4. What categorical label(s) was assigned to this child? *(Specify - will be coded later)*

	CATEGORICAL LABEL	SEVERITY LEVEL	PERSON CONFIRMING HANDICAP	DATE YR	MO	DAY
2,23,24-25,26-31	☐☐ ________	☐	☐☐	☐☐	☐☐	☐☐
3,34,35-36,37-42	☐☐ ________	☐	☐☐	☐☐	☐☐	☐☐
4,45,46-47,48-53	☐☐ ________	☐	☐☐	☐☐	☐☐	☐☐
5,56,57-58,59-64	☐☐ ________	☐	☐☐	☐☐	☐☐	☐☐
66,67,68-69,70-75	☐☐ ________	☐	☐☐	☐☐	☐☐	☐☐

(Interviewer: Codes for Question 4)

SEVERITY	
1	*Normal*
2	*Borderline*
3	*Mild*
4	*Moderate*
5	*Servere*
6	*Profound*
7	*No severity level specified*

DIAGNOSTICIAN/PERSON CONFIRMING HANDICAP	
01	*Physician*
02	*Nurse*
03	*Psychologist/psychiatrist*
04	*Speech pathologist*
05	*Social worker*
06	*Nutritionist/dietician*
07	*Certified special education teacher*
08	*Physical therapist*
09	*Occupational therapist*
10	*Ophthalmologist/optometrist*
11	*Audiologist*
12	*Head Start teacher*
13	*Other (specify)* ______________

5. Functional Assessment

		TECHNIQUE (*specify - will be coded later*)	DEVELOPMENTAL AREA	WHO PERFORMED ASSESSMENT	DATE OF ASSESSMENT YR MO DAY	WAS A LEVEL OF PERFORMANCE SPECIFIED?	DID REPORTING OF ASSESSMENT INCLUDE STATEMENT OF WHAT CHILD CAN/CAN NOT DO?
18,19,20,21-26,27,28	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
29,30,31,32-37,38,39	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
40,41,42,43-48,49-50	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
51,52,53,54-59,60-61	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
62,63,64,65-70,71,72	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
16-17="03" 18,19,20,21-26,27,28	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
29,30,31,32-37,38,39	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
40,41,42,43-48,49,50	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
51,52,53,54-59,60-61	☐	________	☐	☐	☐☐☐☐☐☐	Yes - 1 No - 2	Yes - 1 No - 2
62	☐	None					

(Interviewer: Codes for Question 5)

DEVELOPMENTAL AREA

1	*cognitive*
2	*communication*
3	*self help*
4	*gross motor*
5	*fine motor*
6	*other (specify)* ________

WHO PERFORMED ASSESSMENT

01	*Physician*
02	*Nurse*
03	*Psychologist/psychiatrist*
04	*Speech pathologist*
05	*Social worker*
06	*Nutritionist/dietician*
07	*Certified Special Education Teacher*
08	*Physical therapist*
09	*Occupational therapist*
10	*Opthalmologist/optometrist*
11	*Audiologist*
12	*Head Start teacher*
13	*Other (specify)* ________

6. Who made recommendations for this child? *(Check all that apply)*

63 ___ Physician
64 ___ Nurse
65 ___ Psychologist/psychiatrist
66 ___ Speech pathologist
67 ___ Social worker
68 ___ Nutritionist/dietician
69 ___ Certified special education teacher
70 ___ Physical therapist
71 ___ Occupational therapist
72 ___ Opthalmologist/optometrist
73 ___ Audiologist
74 ___ Head Start teacher
75 ___ Other *(specify)* ______________________________

76 ___ None made

B. INDIVIDUAL SERVICE PLAN REVIEW GUIDE

-1[illegible]"03" 7. Goals *(specify - will be coded later)*

	COMPONENT AREAS	GOALS	DATE COMPLETED YR		MO		DAY	
),20-25	☐ ________	☐	☐	☐	☐	☐	☐	☐
7,2[illegible]-33	☐ ________	☐	☐	☐	☐	☐	☐	☐
5,36-41	☐ ________	☐	☐	☐	☐	☐	☐	☐
3,[illegible]-49	☐ ________	☐	☐	☐	☐	☐	☐	☐
1,5[illegible]-57	☐ ________	☐	☐	☐	☐	☐	☐	☐
9,[illegible]-65	☐ ________	☐	☐	☐	☐	☐	☐	☐
7,6[illegible]-73	☐ ________	☐	☐	☐	☐	☐	☐	☐
16-1[illegible]="04"								
19,[illegible]-25	☐ ________	☐	☐	☐	☐	☐	☐	☐

(Interviewer: Codes for Question 7)

GOALS

1 *Annual*
2 *Short Term*
3 *Both*
4 *Other (specify)* ____________________

Education Component

8a. Is there a statement of annual goals for the child? 26

2 No
1 Yes

8b. Is there a statement of short-terms goals for the child? 27

2 No
1 Yes

8c. Is there a statement of the specific educational services to be provided? 28

2 No
1 Yes

8d. Is there a statement of objective criteria and evaluation procedures for determining on at least an annual basis whether instructional objectives are being achieved? 29

2 No
1 Yes
→ Specify: ____________________
____
____

C. MONITORING OR PROGRESS REPORTS

		TECHNIQUE USED (*specify - will be coded later*)	DEVELOPMENTAL AREA(S)	USER OF TECHNIQUE	WHEN PERFORMED (*during school year*) YR	MO	DAY
,31,32,33,34,35-36,37-42	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
,44,45,46,47,48-49,50-55	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
,57,58,59,60,61-62,63-68	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
16-17= "05"							
,19,20,21,22,23-24,25-30	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
,32,33,34,35,36-37,38-43	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
,45,46,47,48,49-50,51-56	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
,58,59,60,61,62-63,64-69	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
16-17="06"							
,19,20,21,22,23-24,25-30	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
,32,33,34,35,36-37,38-43	☐	____	☐ ☐ ☐ ☐	☐☐	☐☐	☐☐	☐☐
44	☐	None used					

(Interviewer: Codes for above)

DEVELOPMENTAL AREA

1	*Cognitive*
2	*Communication*
3	*Self help*
4	*Self concept*
5	*Gross motor*
6	*Fine motor*
7	*Other (specify)* ____

USER OF TECHNIQUE

01	*Physician*
02	*Nurse*
03	*Psychologist/psychiatrist*
04	*Speech pathologist*
05	*Social worker*
06	*Nutritionist/dietician*
07	*Certified special education teacher*
08	*Physical therapist*
09	*Occupational therapist*
10	*Opthomologist/optometrist*
11	*Audiologist*
12	*Head Start Teacher*
13	*Other (specify)* ____

OMB# 85-S77002
Expires: 12 / 31/77

EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I DIAGNOSTICIAN/PROFESSIONAL SERVICE PROVIDER SCHEDULE

PART A: INDIVIDUAL'S CHARACTERISTICS

1. Grantee ________________________________
2. Delegate Agency ________________________________

CARD COLUMN		
-5	Program Code: ☐☐☐☐☐	Respondent: ____________________ (profession, position)
-10	Child Code ☐☐☐☐☐	Agency Affiliation: ____________________
11-13	Center Code ☐☐☐	
14-15	Form Number 0 7 H	Program Name: ____________________ ____________________
16-17	Card Number 0 1	
8-22	Diagnostician/Service Provider Number ☐☐☐☐☐	Interviewer: ____________________
		Interview Date: __/__/__

GOOD (MORNING, AFTERNOON), MY NAME IS _______________, AND I REPRESENT APPLIED MANAGEMENT SCIENCES OF SILVER SPRING, MARYLAND. WE'RE UNDER CONTRACT TO THE OFFICE OF CHILD DEVELOPMENT TO REVIEW EFFORTS BEING MADE BY HEAD START PROGRAMS ON BEHALF OF HANDICAPPED CHILDREN. YOU WERE REFERRED TO US BY _______________ (HEAD START DIRECTOR) AS A PROFESSIONAL WHO HAS PROVIDED SERVICES TO HANDICAPPED CHILDREN ENROLLED IN HEAD START. SPECIFICALLY, _______________ (HEAD START DIRECTOR) HAS STATED THAT YOU HAVE PROVIDED SERVICES TO _______________ _______________ (CHILD'S NAME).

IF YOU DON'T MIND, I'D LIKE TO ASK YOU A FEW SHORT QUESTIONS ABOUT THE KINDS OF SERVICES YOU'VE PROVIDED TO THIS CHILD AND ABOUT YOUR INVOLVEMENT WITH HANDICAPPED CHILDREN IN GENERAL. LET ME ASSURE YOU THAT ALL INFORMATION YOU PROVIDE WILL BE KEPT IN THE STRICTEST CONFIDENCE AND THAT THE PARENTS OF _______________ (CHILD'S NAME) ARE AWARE OF OUR STUDY AND HAVE GRANTED PERMISSION TO GATHER INFORMATION ABOUT THEIR (SON'S AND DAUGHTER'S) EXPERIENCE IN HEAD START.

ARE THERE ANY QUESTIONS? (*Interviewer: Be sure to ask the respondent if he/she would like a brief discussion of the purposes of this study and the manner in which data will be utilized by OCD.*)

LET'S BEGIN. WE SHOULD BE FINISHED IN APPROXIMATELY 10-15 MINUTES.

(1)

(Complete only once for each diagnostician/professional service provider)

1. What is your area of professional specialization? *(Circle one)* 3-24

   1 psychologist/psychiatrist
   2 pediatrician
   3 other physician
   4 registered nurse
   5 speech therapist/pathologist
   6 audiologist
   7 optometrist/ophthamologist
   8 physical therapist
   9 occupational therapist
   10 nutritionist/dietician
   11 certified special education teacher
   12 social worker
   13 public health nurse
   14 other *(please specify)* ______________________

2. With what agency/institution are you affiliated? *(Circle one)* -26

   1 none - private practitioner/consultant
   2 public hospital
   3 public school system
   4 local social services department
   5 State social services department
   6 Easter Seal agency
   7 BEH First Chance Project
   8 State institution
   9 other BEH project
   10 other private medical clinic
   11 other private program for the handicapped
   12 State or Regional Head Start staff
   13 other *(please specify)* ______________________

3. Are you paid for your Head Start services?

2 No

1 Yes 27

3a. By whom?

1 Head Start entirely 28

2 Agency/institution with which affiliated

3 Head Start/other agency (joint funding)

4 Other (*please specify*) ______________________

3b. Would you happen to know the source of funds used to pay for your services?

1 local funds 29

2 State funds

Federal grant from:

3 BEH

4 EPSDT

5 other (*please specify*) ____________________

6 don't know, no response

OMB# 85-S77002
Expires: 12 / 31/77

EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I DIAGNOSTICIAN/PROFESSIONAL SERVICE PROVIDER SCHEDULE

PART B: CHILD SPECIFIC DATA

(Complete one for each child assigned to this diagnostician/professional service provider)

CAR COLUMN	
	Program Code:
1-5	☐☐☐☐☐
	Child Code:
6-10	☐☐☐☐☐
	Center Code:
11-13	☐☐☐
	Form Number:
14-15	0 8
-17="01"	
	Diagnostician/Service Provider Number:
18-22	☐☐☐☐☐

1. What specific services have you provided this child? *(Check all that apply)*

2 ___ diagnosis

24 ___ screening

25 ___ therapy *(occupational, physical, speech, etc.)*

26 ___ health services *(medical services)*

27 ___ educational services

28 ___ parental counseling/training

29 ___ teacher/staff training specific to child

30 ___ other *(specify)* ______________________________

(Interviewer: For each service area indicated in Question 1, there is a specific area developed for more detailed information. Please go to each section the respondent has indicated he/she has made input)

DIAGNOSIS:

Head Start views the diagnostic process as involving three major steps. The first of these is the confirmation of a handicapping condition according to specific criteria. The second step is the conduct of a functional assessment to determine what the child can or cannot do. The final step is the development of recommendations based upon the functional assessment for implementing an appropriate program of services for the child.

2. In which of the three diagnostic processes did you participate for this child? *(Check all that apply)*

31 ___ confirmation of handicap

32 ___ functional assessment in area of handicap

33 ___ general functional assessment

34 ___ recommendations in area of handicap

35 ___ general recommendations

3. As a result of your diagnosis, how was this child categorized? *(Check all that apply)*

36 ___ Blind

37 ___ Visually impaired

38 ___ Deaf

39 ___ Hearing impaired

40 ___ Physically handicapped

41 ___ Speech impaired

42 ___ Health or developmentally impaired

43 ___ Mentally retarded

44 ___ Serious emotional disturbance

45 ___ Specific learning disability

4. What techniques did you utilize in conducting your diagnosis? Please respond for each step of the diagnostic process.

Confirmation of handicap (*list a maximum of 4*)

46,47,48,49 ______________________________

____

____

____

(*Interviewer: Record response verbatim. Responses will be coded after field activities are completed*)

Functional Assessment (*check all that apply*)

50 ___ formal (*standardized*) tests

(*specify*) ______________________________

____

51 ___ assessments that are part of a specific curriculum package

(*specify*) ______________________________

____

52 ___ teacher/center designed assessment

53 ___ unstructured observation

54 ___ parent report

55 ___ same technique as in "Confirmation of handicap"

56 ___ other (*specify*) ______________________________

Recommendations (*circle one*)

57 1 written report

2 verbal report

3 other (*specify*) ______________________________

5. Did you discuss your diagnostic report with: (*Check all that apply*)

58 ___ parents

59 ___ child's teacher

60 ___ program coordinator

61 ___ Head Start director

62 ___ other (*specify*) ______________________________

6. Were you a member of a diagnostic team for this child?

63 2 No

1 Yes

7. How did you become involved with the Head Start program? *(Check all that apply)*

64 ___ through children only - not regularly involved with Head Start

65 ___ sought out by Head Start for his/her services on an "as needed" basis

66 ___ referred to Head Start by other agency

67 ___ EPSDT

68 ___ part of regular Head Start diagnostic staff

69 ___ other *(specify)* ______________________________

SCREENING:

8. Please indicate the areas in which you conduct screening for this child and the techniques/methods utilized to conduct this screening. *(Interviewer: List techniques. Coding will be accomplished upon conclusion of field activities)*

Screening Area and Techniques/Methods

vision:

-71 ______________________________ ☐☐

72-73 ______________________________ ☐☐

hearing:

74-75 ______________________________ ☐☐

-77 ______________________________ ☐☐

-17="02"

physical coordination and development:

-19 ______________________________ ☐☐

-21 ______________________________ ☐☐

speech and language:

-23 ______________________________ ☐☐

24-25 ______________________________ ☐☐

intellectual development:

26-27 ______________________________ ☐☐

-29 ______________________________ ☐☐

Screening Area and Techniques/Methods (continued)

emotional development:

30-31 ______________________________ ☐☐

32-33 ______________________________ ☐☐

social development:

34-35 ______________________________ ☐☐

36-37 ______________________________ ☐☐

(Interviewer: Record responses verbatim. Coding will be done after completion of field activities)

9. How did you become involved with the Head Start program? *(Check all that apply)*

38 ___ through children only - not regularly with Head Start

39 ___ sought out by Head Start for services on an "as needed" basis

40 ___ referred to Head Start by other agency

41 ___ EPSDT

42 ___ part of regular Head Start screening staff

43 ___ other *(specify)* ______________________________

THERAPY: *(occupational, physical, speech - other non-medical treatment services)*

10. What special therapeutic services do you provide to this child? *(Interviewer: Record response verbatim. Coding will be done after completion of field activities)*

44 ☐ ______________________________

45 ☐ ______________________________

46 ☐ ______________________________

47 ☐ ______________________________

48 ☐ ______________________________

49 ☐ ______________________________

11. How did you become involved with the Head Start program? *(Check all that apply)*

50 ___ services predate child's Head Start enrollment

51 ___ sought out by Head Start

52 ___ sought out by parents/other agency after child's enrollment in Head Start, but coordinate with Head Start

53 ___ sought out by parents/other agency after child's enrollment in Head Start, and no coordination with Head Start

54 ___ part of regular Head Start handicapped effort

55 ___ other *(specify)* ______________________________

HEALTH SERVICES: *(medical treatment services requiring physician, registered nurse, paramedical, pharmacists)*

12. What special health services do you provide to this child? *(Check all that apply)*

56 ___ regular medical/dental examinations and follow-up

57 ___ prescription and monitoring of pharmaceuticals

58 ___ surgical services *(specific to handicap)*

59 ___ nutritional planning and monitoring

60 ___ treatment of allergies and handicap-related syndromes

61 ___ prosthetic services *(fitting and montoring)*

62 ___ other *(specify)* ________________________

63 ___ other *(specify)* ________________________

13. How did you become involved with the Head Start program? *(Check all that apply)*

64 ___ services predate child's Head Start enrollment

65 ___ sought out by Head Start

66 ___ sought out by parents/other agency after child's enrollment in Head Start, but coordinated with Head Start

67 ___ sought out by parents/other agency after child's enrollment in Head Start, and no coordination with Head Start

68 ___ part of regular Head Start handicap effort

69 ___ other *(specify)* ________________________

EDUCATIONAL SERVICES: *(Interviewer: Be sure respondent understands the definition of educational services as indicated in your manual)*

14. What specific educational services have you provided to this child? *(Check all that apply)*

70 ___ developed educational objectives/program

71 ___ worked with child at Head Start center

72 ___ worked with child at home or location other than Head Start center

73 ___ conducted educational assessments on child

74 ___ other *(specify)* ________________________

16-17="03" 15. In what specific developmental areas have you provided education services to this child? *(Check all that apply)*

18 ___ cognitive

19 ___ communication skills

20 ___ self-help skills

21 ___ self-concept skills

22 ___ gross motor skills

23 ___ fine motor skills

24 ___ behavior management

25 ___ other *(specify)* ____________________

16. If you work directly with this child, approximately how many hours a week are involved? *(Circle one)*

26 1 1-3 hours

2 4-8 hours

3 9-12 hours

4 over 12 hours

5 other (e.g., once a month, etc.) *(specify)* ____________

17. How did you become involved in the Head Start program? *(Check all that apply)*

27 ___ services predate child's Head Start enrollment

28 ___ sought out by Head Start

29 ___ sought out by parents/other agency after child's enrollment in Head Start, but coordinated with Head Start

30 ___ sought out by parents/other agency after child's enrollment in Head Start, and no coordination with Head Start

31 ___ part of regular Head Start handicap effort

32 ___ other *(specify)* ____________________

PARENTAL COUNSELING/TRAINING:

18. What specific counseling/training services have you provided to the parents/guardians of this child? *(Check all that apply)*

33 ___ interpretation of diagnostic file

34 ___ nutritional/health counseling

35 ___ behavior management

36 ___ family relations

37 ___ availability of other community resources

38 ___ instructional techniques

39 ___ other *(specify)* ______________________________

19. How did you become involved in the Head Start program? *(Check all that apply)*

40 ___ services predate child's Head Start enrollment

41 ___ sought out by Head Start

42 ___ sought out by parents/other agency after child's enrollment in Head Start, but coordinated with Head Start

43 ___ sought out by parents/other agency after child's enrollment in Head Start, and no coordination with Head Start

44 ___ part of regular Head Start handicap effort

45 ___ other *(specify)* ______________________________

HEAD START STAFF TRAINING:

20. What specific training services have you provided to Head Start staff responsible for the program of services for this child? *(Check all that apply)*

46 ___ knowledge of Head Start performance standards

47 ___ behavior management/modifications

48 ___ individualized instructional techniques

49 ___ preparation of individual learning objectives

50 ___ working with parents

51 ___ strategies for recruitment of handicapped children

52 ___ screening and assessment

53 ___ theory and practice of mainstreaming

54 ___ strategies for working with specific handicapping conditions

55 ___ understanding handicapped children and their special problems

56 ___ other *(specify)* ______________________________

21. How did you become involved in the Head Start program? (*Circle one*)

57

1 services sought by local Head Start program

2 services provided through Regional Head Start staff

3 other (*specify*) ______________________________

OMB # 85-S77002

Expires 12 / 31 / 77

EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I NON-ENROLLED CHILD INTERVIEW SCHEDULE

Program Code:

1-5 ☐☐☐☐☐

Child Code:

6-10 ☐☐☐☐☐

Center Code:

11-13 ☐☐☐

Form Number:

14-15 0 9

1. initial contact __/__/__
2. first follow-up __/__/__
3. second follow-up __/__/__
4. refusal __/__/__

Interviewer: ________________

____

Interview Date: ________________

GOOD (MORNING, AFTERNOON) MY NAME IS______________ AND I REPRESENT APPLIED MANAGEMENT SCIENCES OF SILVER SPRING, MARYLAND. WE HAVE BEEN EMPLOYED BY THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE TO STUDY EFFORTS MADE TO HELP HANDICAPPED CHILDREN. PART OF OUR STUDY INCLUDES OBTAINING INFORMATION FROM CITIZENS WHO HAVE HAD CONTACT WITH HEAD START PROGRAMS. YOU MAY RECALL THAT WE SENT YOU A LETTER RECENTLY ASKING YOUR PERMISSION TO TALK TO YOU ABOUT YOUR (SON), (DAUGHTER) ______________(CHILD'S NAME). THE REASON WE WOULD LIKE TO TALK TO YOU IS TO FIND OUT WHY YOUR (SON), (DAUGHTER) WAS NOT ABLE TO ATTEND ________________(PROGRAM NAME). THIS PROGRAM IS A PART OF HEAD START.

PLEASE UNDERSTAND THAT ANY INFORMATION YOU GIVE US WILL REMAIN STRICTLY PRIVATE. NO ONE, NOT EVEN APPLIED MANAGEMENT SCIENCES WILL BE ABLE TO SINGLE OUT YOUR ANSWERS FROM THE ANSWERS GIVEN TO US BY OTHER PARENTS WE'VE TALKED TO.

WE APPRECIATE YOUR COOPERATION IN THIS STUDY.

DO YOU HAVE ANY QUESTIONS?

LET'S BEGIN. WE'LL ONLY TAKE FIVE OR TEN MINUTES OF YOUR TIME.

(1)

16-17 ="01" 1. WHY DID YOU ATTEMPT TO ENTER YOUR (SON)(DAUGHTER) INTO (PROGRAM NAME)?

(Interviewer: You need to find out two points of information from this question. First, try to determine the nature of the child's actual or suspected handicap (record below and try to confirm this information with the Head Start program). Secondly try to find who (professional or agency) referred the parent to Head Start.)

-19 20-21

Handicap *(Circle one)*	Referred by *(Circle one)*
1. don't know	1. friends
2. blind	2. came to Head Start on own
3. visual impairment	3. public schools
4. deaf	4. social worker/social service agency
5. hearing impairment	5. church
6. physical handicap	6. physician
7. health impaired	7. public health nurse
8. speech impaired	8. BEH project
9. mental retardation	9. EPSDT project
10. serious emotional disturbance	10. other specialist
11. specific learning disability	11. other public agency
	12. other private agency
12. multiple handicapped	13. other __________ *(specify)*

2. WHY WAS YOUR CHILD NOT ABLE TO ENTER (PROGRAM NAME)? *(Check all that apply)*

- ___ did not meet income guidelines (1)
- 23 ___ no available openings (2)
- 24 ___ lack of appropriate staff training (3)
- ___ lack of suitable facilities or equipment (4)
- 26 ___ other agencies serve these children (5)
- ___ concern over possible legal liabilities (6)
- ___ behavioral problems (7)
- 29 ___ handicap too severe for child to benefit from Head Start (8)
- ___ felt child's attendance would be detrimental to other children (9)
- ___ child's parents refused (10)
- 32 ___ other parents or parent advisory group objected (11)
- ___ lack of adaquate transportation (12)
- ___ other *(please specify)* ____________________ (13)

2a. *(Interviewer: Try to confirm this reason with the Head Start program:*

1. confirmed

6-37 *2. disagreement*

→ *Head Start's reason:* ☐☐ *enter codes from #2*

3. IS YOUR CHILD NOW IN ANOTHER PROGRAM? *(circle one)*

38 2. no
1 yes

39 → 1. Easter Seal program
2. public school program
3. church-sponsored program
4. BEH First Chance Project
5. other________________ *(specify)*

4. IS YOUR CHILD RECEIVING ANY SERVICES AS A RESULT OF HIS/HER HANDICAP?

40 2 no
1 yes

→ WHAT KIND OF SERVICES? *(Check all that apply)*

41 ___ day care
42 ___ educational instruction
43 ___ family counseling
44 ___ medical/dental treatment
45 ___ occupational/physical therapy
46 ___ other therapy related to handicap
47 ___ other service________________________ *(please specify)*

5. WERE THESE SERVICES ARRANGED THROUGH, OR AS A RESULT OF, CONTACT WITH HEAD START?

48 2 no
1 yes

(Interviewer: Confirm the kind of program the child is now enrolled in and whether it is categorical or non-categorical)

49 1 categorical
2 non-categorical

OMB # 85-S77002

EXPIRES 12 /31 /77

EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO HEAD START

APPLIED MANAGEMENT SCIENCES, INC.

PHASE I ALTERNATE PROGRAM SCHEDULE

Name of Program

____

____

Respondent(s)

____

____

____
(position/function)

Interviewer: ____________________

____

Interview Date: __ / __ / __
YR MO DAY

CARD COLUMN

Head Start Program Code:

1-5 ☐☐☐☐☐

Child Code: *(Leave blank)*

6-10 ☐☐☐☐☐

Center Code: *(Alternative Program)*

11-13 ☐☐☐ *(Boxes 1 and 2 = Unique Identifier*
Box 3 - Code 1 = Private
- Code 2 = Public

Form Number:

14-15 | 1 | 0 |

K

GOOD (MORNING, AFTERNOON), MY NAME IS _______________, AND I REPRESENT APPLIED MANAGEMENT SCIENCES OF SILVER SPRING, MARYLAND. WE'RE UNDER CONTRACT TO THE OFFICE OF CHILD DEVELOPMENT TO REVIEW EFFORTS BEING MADE BY HEAD START PROGRAMS ON BEHALF OF HANDICAPPED CHILDREN.

PART OF THIS STUDY INCLUDES A REVIEW OF SIMILAR EFFORTS BEING MADE BY PROGRAMS OTHER THAN HEAD START. BY COMPARING HEAD START WITH PROGRAMS SUCH AS YOURS, WE HOPE TO OBTAIN INFORMATION THAT WILL ENABLE THE OFFICE OF CHILD DEVELOPMENT TO ESTABLISH STANDARDS AND POLICIES THAT WILL IMPROVE HEAD START'S HANDICAPPED PROGRAM.

YOUR PROGRAM WAS ONE OF MANY SUGGESTED TO US BY HEAD START THAT MAY BE OF HELP IN PROVIDING US WITH THE DATA WE REQUIRE. OUR PRIMARY REASON FOR SPECIFICALLY SELECTING YOUR PROGRAM WAS BECAUSE OUR REVIEW INDICATED THAT YOUR PROGRAM WOULD MOST LIKELY PROVIDE A VIABLE ALTERNATIVE TO THE HANDICAPPED CHILDREN CURRENTLY BEING SERVED BY HEAD START.

PLEASE REALIZE THAT ALL DATA YOU PROVIDE WILL BE KEPT IN STRICT CONFIDENCE. FURTHERMORE, NO ANALYSES WILL BE PROGRAM SPECIFIC. THIS MEANS YOUR PARTICULAR PROGRAM WILL REMAIN ANONYMOUS.

WE APPRECIATE YOUR TIME AND COOPERATION IN THIS STUDY. PLEASE FEEL FREE TO ELABORATE ON ANY QUESTION THAT YOU BELIEVE DOES NOT TRULY REFLECT THE SCOPE OF YOUR HANDICAPPED PROGRAM.

ARE THERE ANY QUESTIONS?

LET'S BEGIN.

16-17 = "01"

1. HOW LONG HAVE YOU BEEN SERVING HANDICAPPED PRESCHOOLERS?

18 1 less than one year

2 1-2 years

3 3-4 years

4 5-7 years

5 8-10 years

6 over 10 years

2. DO YOU SERVE NON-HANDICAPPED PRESCHOOLERS?

19 2 No

1 Yes

3. WOULD YOU CONSIDER YOUR PROGRAM CATEGORICAL OR NON-CATEGORICAL WITH RESPECT TO THE TYPE OF HANDICAP CHILD YOU SERVE?

1 categorical

20 2 non-categorical

3a. WHAT SPECIFIC TYPES OF HANDICAPPED CHILDREN ARE CURRENTLY ENROLLED IN YOUR PROGRAM? *(Primary handicap only - check all that apply)*

21 ___ Blindness

22 ___ Visual Impairment

23 ___ Deafness

24 ___ Hearing Impairment

25 ___ Physical Handicap

26 ___ Speech Impairment

27 ___ Health or Developmental Impairment

28 ___ Mental Retardation

29 ___ Serious Emotional Disturbance

30 ___ Specific Learning Disabilities

31 ___ Other *(please specify)* ______________________________

4. WHAT IS THE TOTAL NUMBER OF PRESCHOOL CHILDREN CURRENTLY ENROLLED IN YOUR PROGRAM?

32-34 ☐☐☐

4a. TOTAL NUMBER OF HANDICAPPED CHILDREN?

35-37 ☐☐☐

5. DO YOU PROVIDE A MAINSTREAM PROGRAM FOR YOUR HANDICAPPED CHILDREN?

38 3 No

2 Yes, but only for non-classroom activities (free play, lunch,etc.)

1 Yes

↳ 5a. WHAT TYPES OF MAINSTREAMING ARE AVAILABLE THROUGH YOUR PROGRAM? *(Hand respondent list of alternatives. Have him/her select all that __are__ offered.)*

39 ___ complete mainstreaming of handicapped child into a regular classroom *(no supportive services provided)*

40 ___ complete mainstreaming of handicapped child into a regular classroom with supportive assistances provided by a specialist

41 ___ complete mainstreaming of handicapped children in a classroom where the regular classroom teacher and a special education teacher cooperatively work with all children *(a team arrangement)*

42 ___ reverse mainstreaming in which normal children become part of a special education class

43 ___ partial mainstreaming where handicapped children are in a special education class but go to mainstreamed classes for one or more regular classroom activities

44 ___ handicapped children receive services from your program but are __not__ mainstreamed

5b. WHAT IS THE APPROXIMATE PERCENTAGE OF CLASS TIME THAT HANDICAPPED CHILDREN SPEND IN A MAINSTREAMED ENVIRONMENT?

5-46 ☐☐ %

6. WHAT IS THE TYPICAL NUMBER OF TEACHERS HAVING INSTRUCTIONAL RESPONSIBILITY IN A GIVEN CLASS IN THIS PROGRAM? *(Class must include at least one handicapped child)*

-48 ☐☐ (full-time)

-50 ☐☐ (including members of an instructional team)

6a. WHAT IS THE TYPICAL NUMBER OF OTHER ADULTS (AIDES, VOLUNTEERS, ETC.) THAT ARE USUALLY PRESENT IN A GIVEN CLASS? *(Class must include at least one handicapped child)*

-52 ☐☐

6b. WHAT IS THE TYPICAL NUMBER OF CHILDREN IN A CLASSROOM IN THIS PROGRAM IN WHICH THERE IS AT LEAST ONE HANDICAPPED CHILD?

53-54 ☐☐

Interviewer: From #6, #6a., and #6b., compute typical

55-5 *teacher/child ratio:* .☐☐ *6 divided by 6b*

-58 *adult/child ratio:* .☐☐ *6a divided by 6b*

7. PLEASE INDICATE THE QUALIFICATIONS OF EXISTING CLASSROOM STAFF WHO HAVE RESPONSIBILITY FOR AT LEAST ONE HANDICAPPED CHILD. *(Enter number in each category)*

		TEACHER	AIDES	OTHER *(specify)*	
	EDUCATION				
-60 61-62,63-64	1. less than high school	☐☐	☐☐	☐☐	________
-66,67-68,69-70	2. high school graduate	☐☐	☐☐	☐☐	________
-7 73-74,75-76 16-17 = "02"	3. associate degree/some college but no B.A./B.S.	☐☐	☐☐	☐☐	________
-19 20-21,22-23	4. college graduate	☐☐	☐☐	☐☐	________
-25,26-27,28-29	5. postgraduate education (degreed or otherwise)	☐☐	☐☐	☐☐	________
7b.	**DEGREE AREA**				
-31,32-33,34-35	1. degree in special education	☐☐	☐☐	☐☐	________
-3 38-39,40-41	2. degree in early childhood development	☐☐	☐☐	☐☐	________
-43,44-45,46-47	3. other degree area	☐☐	☐☐	☐☐	________
7c.	**CERTIFICATION**				
-49,50-51,52-53	1. State certified for special education	☐☐	☐☐	☐☐	________
-3 56-57,58-59	2. other *(specify)* ________	☐☐	☐☐	☐☐	________

____

8. WHAT TYPES OF INSERVICE TRAINING HAS YOUR CLASSROOM STAFF RECEIVED RELATED TO HANDICAPPED CHILDREN? *(Staff must be those with responsibility for at least one handicapped child)*

	TYPE OF TRAINING	PRIMARY PROVIDER	HOURS OF TRAINING	RECIPIENTS
2-63,64,65,66	☐	☐	☐☐	☐ ☐ ☐
9-70,71,72,73	☐	☐	☐☐	☐ ☐ ☐
6-77,78,79,80 16-17 = "03"	☐	☐	☐☐	☐ ☐ ☐
0-21,22,23,24	☐	☐	☐☐	☐ ☐ ☐
7-28,29,30,31	☐	☐	☐☐	☐ ☐ ☐

(Interviewer: Codes for #8)

TRAINING TYPE

1 *behavior management/modification*

2 *individualized instructional techniques*

3 *preparation of individual learning objectives*

4 *working with parents*

5 *strategies for recruitment of handicapped children*

6 *screening and assessment*

7 *general introduction to child development and handicapping conditions*

8 *other (specify)* ______________________________

PROVIDER

1 *public school system*

2 *University/college affiliate*

3 *public health department*

4 *private clinician (consultant)*

5 *State Department of Education*

6 *other (specify)* ______________________________

RECIPIENTS

1 *teacher*

2 *aide*

3 *other*

SCREENING

NOW WE'D LIKE TO ASK YOU A FEW QUESTIONS ABOUT THE WAY IN WHICH YOUR PROGRAM RECRUITS AND SCREENS CHILDREN.

9. DO YOU HAVE ESTABLISHED RECRUITMENT PROCEDURES FOR HANDICAPPED CHILDREN?

32 1 No, admission is based upon parent application

2 Yes, we have our own outreach and child find activities to locate handicapped children

3 Yes, we are part of an established community referral system, but we make no efforts to actually seek out handicapped children

4 Yes, we are part of an established community referral system, and we also have our own outreach and "child find" activities

5 Other *(specify)* ______________________________

____

(Interviewer: Be sure to take the time to explain each of the options carefully in accordance with the instructions in your manual)

9a. FROM WHAT AGENCIES OR INSTITUTIONS HAVE YOU RECEIVED REFERRALS FOR PLACEMENT OF A HANDICAPPED CHILD? *(Check all that apply)*

33 ___ private practitioner/consultant

34 ___ hospital (public)

35 ___ public or State health department

36 ___ social services department (local or State agency)

37 ___ public school system

38 ___ Easter Seals

39 ___ Crippled Children Association

40 ___ Association for Retarded Children

41 ___ BEH First Chance Project

42 ___ University Affiliated Facilities

43 ___ Head Start program

44 ___ other *(specify)* ______________________________

10. DO YOU PROVIDE SCREENING SERVICES FOR YOUR ENROLLEES TO IDENTIFY CHILDREN WITH POTENTIAL HANDICAPS?

45 2 No, enrollees are identified as handicapped before entering program *(Go to question #12)*

1 Yes, we screen enrollees at the time of program admission

3 Other *(specify)* ______________________________

11. PLEASE INDICATE 1) WHO PROVIDED SCREENING SERVICES IN EACH OF THE FOLLOWING DEVELOPMENTAL AREAS, 2) THE AGENCY(S) WITH WHICH THE PROVIDER(S) IS ASSOCIATED, 3) THE SCREENING TECHNIQUES GENERALLY UTILIZED, AND 4) WHETHER THESE SERVICES ARE PROVIDED TO ALL ENROLLEES OR ONLY A SELECTED NUMBER. *(Fill in boxes to the right with appropriate codes from page 6)*

	SCREENING SERVICES	PROVIDER					AGENCY		TECHNIQUE	GENERAL OR SPECIFIC
7,48,49-50,51-52,53-54,55,56	vision	☐	☐	☐	☐☐	☐☐	☐☐	☐☐	☐	☐
8,59,60-61,62-63,64-65,66,67	hearing	☐	☐	☐	☐☐	☐☐	☐☐	☐☐	☐	☐
9,70,71-72,73-74,75-76,77,78	physical development	☐	☐	☐	☐☐	☐☐	☐☐	☐☐	☐	☐
16-17 = "04"										
9,20,21-22,23-24,25-26,27,28	speech and language	☐	☐	☐	☐☐	☐☐	☐☐	☐☐	☐	☐
0,31,32-33,34-35,36-37,38,39	intellectual development	☐	☐	☐	☐☐	☐☐	☐☐	☐☐	☐	☐
1,42,43-44,45-46,47-48,49,50	social/ emotional development	☐	☐	☐	☐☐	☐☐	☐☐	☐☐	☐	☐

DEVELOPMENT OF DIAGNOSTIC FILE

NOW THAT WE HAVE DISCUSSED THE MANNER IN WHICH CHILDREN ARE SCREENED FOR POTENTIAL HANDICAPS, LET'S TALK ABOUT THE DEVELOPMENT OF DIAGNOSTIC FILES. WHEN WE REFER TO A DIAGNOSTIC FILE, WE REFER TO THOSE DOCUMENTS, REPORTS, TESTS, AND OBSERVATIONS WHICH 1) CONFIRM THE NATURE OF A CHILD'S HANDICAP (PART A); 2) DESCRIBE WHAT THE CHILD CAN AND CANNOT DO IN THE BASIC DEVELOPMENTAL AREA (PART B - FUNCTIONAL ASSESSMENT); AND 3) OFFER RECOMMENDATIONS FOR THERAPY, INSTRUCTIONAL INTERVENTION AND SERVICE DELIVERY (PART C - RECOMMENDATIONS)

12. DOES YOUR PROGRAM DEVELOP A DIAGNOSTIC FILE WHICH ADDRESSES THE THREE COMPONENT AREAS PREVIOUSLY DISCUSSED?

1 yes

51 2 no

↳ 12a. Which components are generally absent? *(Check all that apply)*

52 ___ Part A

53 ___ Part B

54 ___ Part C

13. PLEASE INDICATE FOR EACH OF THE COMPONENTS OF THE DIAGNOSTIC FILE 1) WHO PROVIDED THE DIAGNOSTIC SERVICE, 2) THE AGENCY WITH WHICH THE PROVIDER(S) WAS ASSOCIATED AND 3) WHAT METHODS OR TECHNIQUES WERE UTILIZED.

	DIAGNOSTIC AREA	PROVIDER	AGENCY	TECHNIQUES
	Vision			
55,56,57,58-59,60-61,62-63,64,65,66	confirmation	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
67,[illegible]8,69,70-71,72-73,74-75,76,77,78 16-17 = "05"	assessment	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
18,19,20,21-22,23-24,25-26,27,28,29	recommendations	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
	Hearing			
30,[illegible]1,32,33-34,35-36,37-38,39,40,41	confirmation	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
42,43,44,45-46,47-48,49-50,51,52,53	assessment	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
54,[illegible]5,56,57-58,59-60,61-62,63,64,65	recommendations	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
	Physical Coordination and Development			
66,[illegible]7,68,69-70,71-72,73-74,75,76,77 16-17 = "06"	confirmation	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
18,19,20,21-22,23-24,25-26,27,28,29	assessment	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
30,[illegible]1,32,33-34,35-36,37-38,39,40,41	recommendations	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
	Intellectual Development			
42,[illegible]3,44,45-46,47-48,49-50,51,52,53	confirmation	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
54,[illegible]5,56,57-58,59-60,61-62,63,64,65	assessment	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
66,[illegible]7,68,69-70,71-72,73-74,75,76,77 16-17 = "07"	recommendations	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
	Speech and Language			
18,19,20,21-22,23-24,25-26,27,28,29	confirmation	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
30,[illegible]1,32,33-34,35-36,37-38,39,40,41	assessment	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
42,43,44,45-46,47-48,49-50,51,52,53	recommendations	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
	Social/Emotional Development			
54,55,56,57-58,59-60,61-62,63,64,65	confirmation	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
66,[illegible]7,68,69-70,71-72,73-74,75,76,77 16-17 = "08"	assessment	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐
18,19,20,21-22,23-24,25-26,27,28,29	recommendations	☐ ☐ ☐	☐☐ ☐☐ ☐☐	☐ ☐ ☐

14. ARE ANY OF YOUR DIAGNOSTIC SERVICES FUNDED THROUGH EPSDT (EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM)?

1 No

2 Yes, on occasion

3 Yes, much of our diagnostic effort is funded through EPSDT

15. ARE PARENTS EVER INCLUDED AS A PART OF A DIAGNOSTIC TEAM?

1 No

2 Yes, but rarely

3 Yes, most of the time

4 Don't know

16. ARE DIAGNOSTIC RESULTS AND RECOMMENDATIONS PRESENTED AND EXPLAINED TO PARENTS? *(Check one)*

___ [1 | 0] No, not generally

___ [2 | ☐] Yes, generally by diagnostician/diagnostic team

___ [3 | ☐] Yes, generally by program staff

___ [4 | ☐] Yes, generally by staff/diagnostician together

→ 16a. How are results communicated?

Code written response as "1", verbal report (meeting) as "2", and both as "3" in the boxes next to the method selected.

17. WHY DID YOU USE THE PARTICULAR DIAGNOSTIC SERVICE PROVIDERS INDICATED IN #13? *(Enter one general reason in the box for each particular diagnostic service provided)*

DIAGNOSTIC AREA	REASON
vision	☐
hearing	☐
physical development and coordination	☐
speech and language	☐
intellectual development	☐
social/emotional development	☐

REASON CODES

1 least expensive service available

2 best service available

3 only available service

4 part of established diagnostic service with which your program is associated (public schools, EPSDT)

5 no choice in the matter - children are generally diagnosed prior to enrollment *(other than #4)*

6 other *(specify)*

____

PROGRAM SERVICES

TO THIS POINT WE'VE DISCUSSED HOW CHILDREN ENTER YOUR PROGRAM AND THE SERVICES YOU UTILIZE TO SCREEN AND DIAGNOSE THESE CHILDREN. WE'D NOW LIKE TO ASK A FEW QUESTIONS ABOUT THE SERVICES ACTUALLY PROVIDED TO CHILDREN IN YOUR PROGRAM.

18. DO YOU DEVELOP INDIVIDUAL PLANS OF SERVICES FOR YOUR HANDICAPPED ENROLLEES?

40 2 No

1 Yes

8a. IS THIS A WRITTEN PLAN?

41 2 No

1 Yes

8b. DOES THIS PLAN INCLUDE AN INDIVIDUALIZED EDUCATIONAL PLAN?

42 3 No

2 Yes, and that is all the plan includes

1 Yes, as well as plans in other service areas
(Check all other components included)

43 ___ health

44 ___ social services

45 ___ parental involvement

46 ___ special therapy

47 ___ other *(specify)* ______________________

LET'S DISCUSS SPECIFIC ACTIVITIES THAT YOU MAY HAVE PLANNED FOR HANDICAPPED CHILDREN IN YOUR PROGRAM. IF YOU HAVE ANY QUESTIONS ABOUT DEFINITIONS OF THE ACTIVITY AREAS INDICATED, PLEASE FEEL FREE TO ASK FOR CLARIFICATION.

19. PLEASE INDICATE IF YOU HAVE PLANNED OBJECTIVES FOR HANDICAPPED CHILDREN IN EACH OF THE FOLLOWING ACTIVITY AREAS: *(Circle one for each area)*

	OBJECTIVE AREA	PLANNED FOR HANDICAPPED AND NON-HANDICAPPED THE SAME WAY	PLANNED FOR ALL HANDICAPPED CHILDREN THE SAME WAY (FOR ALL HANDICAPPED CLASSES)	INDIVIDUALLY PLANNED FOR EACH HANDICAPPED CHILD
48	cognitive	1	2	3
49	communication skills	1	2	3
50	self-help	1	2	3
51	self-concept	1	2	3
52	gross motor	1	2	3
53	fine motor	1	2	3
54	other *(specify)*	1	2	3

____

____

20. NOW LET'S DISCUSS THE SPECIFIC ACTIVITIES THAT YOU ACTUALLY CONDUCT FOR HANDICAPPED CHILDREN. THAT IS, THE PREVIOUS QUESTION ADDRESSED YOUR PLANS. THIS QUESTION ADDRESSES THE WAY IN WHICH THESE PLANS ARE USUALLY IMPLEMENTED. *(Interviewer: Coding procedures are the same as for #19)*

	OBJECTIVE AREA	CONDUCTED THE SAME WAY FOR HANDICAPPED AND NON-HANDICAPPED CHILDREN	CONDUCTED THE SAME WAY FOR ALL HANDICAPPED CHILDREN (FOR ALL HANDICAPPED CLASSES)	OFTEN CONDUCTED INDIVIDUALLY FOR EACH HANDICAPPED CHILD
55	cognitive	1	2	3
56	communication skills	1	2	3
57	self-help	1	2	3
58	self-concept	1	2	3
59	gross motor	1	2	3
60	fine motor	1	2	3
61	other *(specify)*			

____

____

21. DO YOU USE SPECIFIC WRITTEN CURRICULA FOR ANY OF THE ABOVE-REFERENCED OBJECTIVE AREAS? 62

2 No

1 Yes

→ 21a. PLEASE SPECIFY THE TYPE OF CURRICULUM BY OBJECTIVE AREA, WHETHER YOU USE IT AS ORIGINALLY DEVELOPED OR MODIFIED, AND WHETHER THE MATERIALS ARE PERFORMANCE BASED OR EXPERIENCED BASED.

(Interviewer: Take time to elaborate on this request. First, ask for curricula actually used and then check these materials against each objective area)

	OBJECTIVE AREA	CURRICULUM*	ADAPTED	FORMAL/ INFORMAL	PERFORMANCE/ EXPERIENCE	GENERAL/SPECIAL FOR HANDICAPPED
3,64,65,66,67	cognitive	☐	☐	☐	☐	☐
8,[illegible],70,71,72	communication skills	☐	☐	☐	☐	☐
3,[illegible],75,76,77 -17 = "09"	self-help	☐	☐	☐	☐	☐
8,[illegible],20,21,22	self-concept	☐	☐	☐	☐	☐
3,[illegible],25,26,27	gross motor	☐	☐	☐	☐	☐
8,[illegible],30,31,32	fine motor	☐	☐	☐	☐	☐
3,34,35,36,37	other *(specify)* ________ ________	☐	☐	☐	☐	☐

**(Interviewer: Leave this column blank. Complete blank below)*

(Interviewer: Codes for 21a.)

CURRICULUM
1 *Locally designed materials*
2 *(specify)* ______________
3 *(specify)* ______________
4 *(specify)* ______________
5 *(specify)* ______________
6 *(specify)* ______________
(these titles will be coded at later date)

GENERAL CURRICULUM OR SPECIAL HANDICAPPED
1 *used for all children*
2 *used for all handicapped*
3 *used specifically for special children*
4 *other (specify)* ______________

ADAPTED
1 *adapted*
2 *used as written*
3 *other (specify)* ______________

PERFORMANCED BASED/EXPERIENCED BASED
1 *performance based*
2 *experienced based*
3 *mixed*
4 *unknown*
5 *other (specify)* ______________

FORMAL/INFORMAL
1 *written*
2 *informal: unwritten*
3 *mixed*

22. DO YOU REGULARLY MONITOR PROGRESS AGAINST THE PROGRAM OBJECTIVES YOU'VE ESTABLISHED?

2 No

38 1 Yes

→ 22a. HOW IS THIS MONITORING ACCOMPLISHED? *(Insert codes for all that apply)*

		HOW OFTEN?
39	formal (standardized) tests	☐
40	assessments that are part of a specific curriculum package	☐
41	teacher/center designed assessment	☐
42	unstructured observation	☐
43	parent report	☐
44	other *(specify)* ______________________	☐

(Interviewer: Codes for 22a.)

1 *weekly*
2 *monthly*
3 *twice a year*
4 *yearly*
5 *other (specify)* ______________________

45

23. DO YOU UTILIZE THE SERVICES OF PROFESSIONAL SPECIALISTS IN PROVIDING SERVICES FOR YOUR HANDICAPPED CHILDREN?

2 No

1 Yes

→ 23a. PLEASE INDICATE THE SPECIALISTS USED AND THEIR CONTRIBUTION TO YOUR PROGRAM OF ACTIVITIES *(including frequency of services provided)*

	Professional *(Check all that apply)*	INVOLVEMENT AREA *(place X in appropriate boxes)*: Works with child at another site	Works with child in the classroom	Trains/consults with teacher	Trains parents	Evaluates child's progress	Observes in classroom	Other *(specify)*	HOW MUCH TIME IS SPENT WITH THIS CHILD *(Circle one)*: Weekly	Monthly	1-3 times a year	Other	*(Specify)*
46,[illegible],48,49,50,51,52,53,54	___ physician	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
55,56,57,58,59,60,61,62,63	___ nurse	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
64,65,66,67,68,69,70,71,72 16-17 = "10"	___ psychologist/ psychiatrist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
18,[illegible],20,21,22,23,24,25,26	___ speech pathologist/ therapist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
27,28,29,30,31,32,33,34,35	___ social worker	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
36,[illegible],38,39,40,41,42,43,44	___ nutritionist/ dietician	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
45,[illegible],47,48,49,50,51,52,53	___ certified special education teacher	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
54,55,56,57,58,59,60,61,62	___ physical therapist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
63,[illegible],65,66,67,68,69,70,71	___ occupational therapist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
72,[illegible],74,75,76,77,78,79,80 16-17 = "11"	___ ophthamologist/ optometrist	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________
18,[illegible],20,21,22,23,24,25,26	___ other specialist *(specify)* ________ ________	☐	☐	☐	☐	☐	☐	☐	1	2	3	4	________

24. DO YOU COORDINATE YOUR PROGRAM OF SERVICES FOR HANDICAPPED CHILDREN WITH OTHER AGENCIES/INSTITUTIONS IN YOUR COMMUNITY?

27 3 No

2 Yes, on occasion

1 Yes, extensively

→ 24a. PLEASE INDICATE THOSE AGENCIES WITH WHICH YOU COORDINATE TO PROVIDE SERVICES TO SPECIFIC CHILDREN (e.g., COORDINATION FOR PURPOSES OTHER THAN STAFF TRAINING, DIAGNOSIS, OR SCREENING). *(Check all that apply)*

28 ___ private practitioner/consultant

29 ___ hospital (public)

30 ___ public or State health department

31 ___ social services department (local or State agency)

32 ___ public school system

33 ___ Easter Seal

34 ___ Crippled Children Association

35 ___ Association for Retarded Children

36 ___ BEH First Chance Project

37 ___ University Affliated Facilities (UAF)

38 ___ Head Start

39 ___ Other *(specify)* ______________________________

24b. HOW IS THIS INTERAGENCY COORDINATION GENERALLY ESTABLISHED?

40 1 we usually initiate contact after children enroll and needs are identified

2 other agencies generally contact us after children enroll

3 agencies generally providing services prior to child's enrollment

4 other *(specify)* ______________________________

PARENT INVOLVEMENT

NOW WE'D LIKE TO DISCUSS THE WAYS IN WHICH THE PARENTS OF HANDICAPPED CHILDREN ARE INVOLVED IN YOUR PROGRAM.

25. DO YOU HAVE AN ADVISORY COUNCIL OR PROGRAM BOARD THAT INCLUDES PARENTS AS FULL MEMBERS?

41
2 No
1 Yes

26. HOW WOULD YOU CHARACTERIZE THE INVOLVEMENT OF PARENTS IN YOUR PROGRAM?

42
1 very active
2 average involvement
3 only minor involvement
4 do not participate at all

27. PLEASE INDICATE THE WAYS IN WHICH PARENTS ARE INVOLVED IN YOUR GENERAL PROGRAM ACTIVITIES? *(Check all that apply)*

43 ___ no involvement
44 ___ parents provide transportation for children
45 ___ parents train or counsel other parents (i.e., a parent trained in a skill shares that skill with other parents)
46 ___ parents involved in outreach and recruitment of other handicapped children
47 ___ parents involved in developing a community resource file
48 ___ parents helped develop objectives for social services and parent involvement
49 ___ parents contributed by making or donating materials for the classroom
50 ___ parents involved in functions with parents of other normal children (social functions, class functions, etc.)
51 ___ other *(specify)* ______________________________
52 ___ other *(specify)* ______________________________

28. IN WHICH OF THE FOLLOWING AREAS DO YOU PROVIDE SPECIFIC TRAINING TO THE PARENTS OF HANDICAPPED CHILDREN? *(Check all that apply)*

53 ___ none

54 ___ assessment

55 ___ program goals and objectives

56 ___ normal child growth and development

57 ___ identifying special needs of their child

58 ___ educational planning

59 ___ availability of other community resources

60 ___ legal rights related to their child

61 ___ genetic counseling

62 ___ emergency first aid

63 ___ information concerning their child's specific handicap

64 ___ home management of the child and activities for parent to do with child

65 ___ other *(specify)* ______________________________

28a. IS THIS TRAINING GENERALLY PROVIDED INDIVIDUALLY AS NEEDED OR AS PART OF A GENERAL PARENT TRAINING PROJECT DEVELOPED BY YOUR PROGRAM?

66
1 individually as needed (generally)
2 general parent training program (generally)
3 both
4 other *(specify)* ______________________________

GENERAL PROGRAM INFORMATION

FINALLY, WE'D LIKE TO ASK YOU SOME ADDITIONAL GENERAL QUESTIONS ABOUT YOUR PROGRAM'S OPERATIONS. THESE QUESTIONS MAY BE COMPLETED PRIOR TO OUR SITE VISIT, IF YOU SHOULD DESIRE TO DO SO.

29. PLEASE INDICATE THE NUMBER OF HANDICAPPED CHILDREN YOU SERVE BY CHRONOLOGICAL AGE:

67-69 3 years old ☐☐☐

0-72 4 years old ☐☐☐

73-75 5 years old ☐☐☐

6-78 other ______ *(specify)* ☐☐☐

16-17 = "12" 29a. OF YOUR CURRENTLY ENROLLED HANDICAPPED CHILDREN, HOW MANY HAVE BEEN OR WILL BE IN YOUR PROGRAM TWO OR MORE YEARS?

18-20 ☐☐☐ *(indicate number)*

30. PLEASE CHECK THE ENTRANCE REQUIREMENTS FOR A HANDICAPPED CHILD TO QUALIFY FOR ENROLLMENT IN YOUR PROGRAM. *(Check all that apply)*

21 ___ chronological age

22 ___ certain handicapping condition(s)

23 ___ certain severity level of these handicapping conditions

24 ___ must be ambulatory

25 ___ must be toilet trained

26 ___ must be functioning at a minimum developmental level

27 ___ parents must make a commitment to participate in the program

28 ___ family must meet income guidelines

29 ___ family must be able to pay tuition

30 ___ child must have received professional diagnosis

31 ___ other *(specify)* ______________________________

31. WHAT IS YOUR TOTAL FUNDING FOR FISCAL YEAR 1977?

32-37 $ ☐☐☐☐☐☐

32. OF THESE FUNDS, WHICH HAVE YOU SPECIFICALLY EARMARKED (ALL OR A PORTION) FOR SERVICES TO THE HANDICAPPED. PLEASE INDICATE SOURCE, AMOUNT, AND LENGTH OF TIME YOU HAVE RECEIV[illegible] THESE FUNDS.

	SOURCE OF FUNDS (*enter appropriate code*)	A[illegible]NT (*enter figure*)	NUMBER OF YEARS RECEIVED (*enter number*)
,39-42,43-44	☐	☐☐☐☐	☐☐
,46-49,50-51	☐	☐☐☐☐	☐☐
,53-56,57-58	☐	☐☐☐☐	☐☐
,60-63,64-65	☐	☐☐☐☐	☐☐
,67-70,71-72 16-17 = "13"	☐	☐☐☐☐	☐☐
,19-22,23-24	☐	☐☐☐☐	☐☐
,26-29,30-31	☐	☐☐☐☐	☐☐
,33-36,37-38	☐	☐☐☐☐	☐☐

CODES FOR FUNDING SOURCE

1 BEH First Chance funds
2 State "reimbursement of services" funds
3 other State funds
4 other local funds
5 other Federal funds
6 other Education for the Handicapped Act funds
7 parent tuition
8 other (*specify*) ______________________
9 other (*specify*) ______________________

33. DO YOU RECEIVE INKIND SERVICES FOR THE HANDICAPPED CHILDREN IN YOUR PROGRAM?

2 No

39 1 Yes

(Please provide the following information only if inkind services are a major segment of your program)

WHAT SERVICES ARE PROVIDED?	WHO/WHAT AGENCY PROVIDES THE SERVICES?	ESTIMATE OF DOLLAR VALUE

TOTAL ☐☐☐☐☐☐ 40-45

APPENDIX C

Head Start Diagnostic Criteria
and
Applied Management Sciences' Severity Descriptors

DIAGNOSTIC CRITERIA* FOR REPORTING HANDICAPPED CHILDREN IN HEAD START

BLINDNESS

A child shall be reported as blind when any one of the following exist: (a) child is sightless or who has such limited vision that he/she must rely on hearing and touch as his/her chief means of learning; (b) a determination of legal blindness in the State of residence has been made; (c) central acuity does not exceed 20/200 in in the better eye, with correcting lenses, or whose visual acuity is greater than 20.200, but is accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle of no greater than 20 degrees.

VISUAL IMPAIRMENT (HANDICAP)

A child shall be reported as visually impaired if central acuity, with corrective lenses, does not exceed 20/70 in either eye, but who is not blind; or whose visual acuity is greater than 20/70, but is accompanied by a limitation in the field of vision such that the widest diameter of visual field subtends an angle of no greater than 140 degrees or who suffers any other loss of visual function that will restrict learning processes, e.g., faulty muscular action. *Not to be included in this category are persons whose vision with eyeglasses is normal or nearly so.*

DEAFNESS

A child shall be reported as deaf when any one of the following exist: (a) his/her hearing is extremely defective so as to be essentially nonfunctional for the ordinary purposes of life; (b) hearing loss is greater than 92 decibels (ANSI 1969) in the better ear; (c) legal determination of deafness in the State of residence.

HEARING IMPAIRMENT (HANDICAP

A child shall be reported as hearing impaired when any one of the following exist: (a) the child has slightly to severely defective hearing, as determined by his/her ability to use residual hearing in daily life, sometimes with the use of a hearing aid; (b) hearing loss from 26-92 decibels (ANSI 1969) in the better ear.

PHYSICAL HANDICAP (ORTHOPEDIC HANDICAP)

A child shall be reported as crippled or with an orthopedic handicap who has a condition which prohibits or impedes normal development of gross or fine motor abilities. Such functioning is impaired as a result of conditions associated with congenital anomalies, accidents, or diseases; these conditions include for example spina bifida, loss of or deformed limbs, burns which cause contractures, cerebal palsy.

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*Via OCD-HS Transmittal Notice of 9/11/75: ANNOUNCEMENT OF DIAGNOSTIC CRITERIA FOR REPORTING HANDICAPPED CHILDREN IN HEAD START

(Continued)

SPEECH IMPAIRMENT (COMMUNICATION DISORDER)

A child shall be reported as speech impaired with such identifiable disorders as receptive and/or expressive language impairment, stuttering, chronic voice disorders, and serious articulation problems affecting social, emotional, and/or educational achievement; and speech and language disorders accompanying conditions of hearing loss, cleft palate, cerebal palsy, mental retardation, emotional disturbance, multiple handicapping conditions, and other sensory and health impairments. *This category excludes conditions of a transitional nature consequent to the early developmental processes of the child.*

HEALTH OR DEVELOPMENTAL IMPAIRMENT

These impairments refer to *illnesses of a chronic nature or with prolonged convalescence* including, but not limited to, epilepsy, hemophilia, severe asthma, severe cardiac conditions, severe anemia or malnutrition, diabetes, or neurological disorders.

MENTAL RETARDATION

A child shall be considered mentally retarded who, during the early developmental period, exhibits significant sub-average intellectual functioning accompanied by impairment in adaptive behavior. *In any determination of intellectual functioning using standardized tests that lack adequate norms for all racial/ethnic groups at the preschool age, adequate consideration should be given to cultural influences as well as age and developmental level (i.e., finding of a low I.Q. is never by itself sufficient to make the diagnosis of mental retardation).*

SERIOUS EMOTIONAL DISTURBANCE

A child shall be considered seriously emotionally disturbed who is identified by professionally qualified personnel (psychologist or psychiatrist) as requiring special services. This definition would include but not be limited to the following conditions: dangerously aggressive towards others, self-destructive, severely withdrawn and non-communicative, hyperactive to the extent that it affects adaptive behavior, severely anxious, depressed or phobic, psychotic or autistic.

SPECIFIC LEARNING DISABILITIES

Children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and development aphasia. Such term does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, or mental retardation, of emotional disturbance, or of environmental disadvantage. *For preschool children, precursor functions to understanding and using language spoken or written, and computational or reasoning abilities are included.* (Professionals considered qualified to make this diagnosis are physicians and psychologists with evidence of special training in the diagnosis of learning disabilities and at least Master's degree level special educators with evidence of special training in the diagnosis of learning disabilities.)

SEVERITY LEVEL DESCRIPTORS FOR EACH HANDICAPPING CONDITION

Handicapping Condition	SEVERITY LEVEL			
	Mild	Moderate	Severe	Profound
Hearing Impairment	30-45 decibels: Understands conversational speech at a distance of 3 to 5 feet without too much difficulty in school if talker's voice is faint or if the face is not visible.	45-60 decibels: Conversational speech needs to be loud to be understood and there is considerable difficulty in group and classroom discussion. Language, especially vocabulary, may begin to be limited and deviations of articulation and voice are noted.	60-80 decibels: May hear voice about one foot from the ear, may identify environmental noises and may distinguish vowels but have difficulty with consonants. Voice may show signs of deviation, but speech and language need to be taught.	80 plus decibels: May hear some loud sounds. Speech and language need to be developed through training.
Visual Impairment	Vision impairment is correctable with corrective lenses or medical treatment and does not impede normal functioning	Visual impairment is not totally correctable with corrective lenses and requires surgical or habilitative intervention. Normal visual functioning is impaired and modifications of classroom activities or materials is needed.	Normal visual functioning is substantially impaired and even with intervention requires development of other sensory systems to compensate for the deficiency in the visual system.	Child is legally blind or impaired in the visual channel to a degree precluding the use of
Communication Disorder (Speech Impairment)				
Receptive or Expressive Language Impairment	Delayed 6 months or less	Delayed 6 months to 1 year	Delayed one to two years	Delayed more than two years
Articulation Impairment	Speech noticeably defective but readily intellegible	Speech is noticeably defective but intelligible with careful listening	Speech is not readily intelligible without contextual cues	Speech is total unintelligible.
(Stuttering)	Stuttering on less than 2 percent of words; tension scarcely perceptible; very few, if any, disfluencies last as long as a full second; patterns of disfluency simple; no conspicuous associated movements of body, arms, legs, or head.	Stuttering on about 3 to 12 percent of words; consistently noticeable tension; disfluencies average about 2 seconds in duration; a few distracting sounds and facial grimaces; a few distracting associated movements	Stuttering on 12 to 25 percent of words; very conspicuous tension; disfluencies average 3 to 4 seconds in duration; very conspicuous distracting sounds and facial grimaces; very conspicuous distrcting associated movements	So dysfluent that speech is seldom produced more than 1 or 2 words at a time.

(Continued)

Handicapping Condition	SEVERITY LEVEL			
	Mild	Moderate	Severe	Profound
Health Impaired	The health condition or disease limits the child's participation in classroom activities. Usually medication and/or dietary control assist in maintenance of the near-normal health condition. Some examples are: seizure disorders controlled with medication, heart conditions, anemia.	A moderately health impaired child is one whose health status is subject to change, often quite suddenly and unexpectedly, or will demonstrate no improvement. While at times his handicap may cause minimal problems, at other times it becomes disabling to the point of hospitalization. His disease or condition can thus seriously impact his ability to progress at a scheduled pace and to function independently. Examples include: leukemia, sickle cell anemia, epilepsy, diabetes, muscular dystrophy, heart defects, and asthma.	The child is one who cannot function alone, his/her health status is completely unstable. This child is unable to care for his basic needs. Examples include the uncontrolled diabetic and uncontrolled epileptic.	The child is unable to care forr any bodily needs. Medication and/or dietary regulation are more important and take precedent over any educational programming which could be provided. Child may be completely bedridden.
Physical Handicap	Noticably physically impaired but not impeded for normal functioning.	Physical impairment requires prosthetic for normal functioning or normal function is somewhat impaired.	Physical impairment prevents normal functioning such as ambulation or eye-hand function.	Physical impairment prevents all motoric functioning (i.e., quadraplegic).
Learning Disabled, Mentally Retarded, Emotionally Disturbed	A child who is unable to perform skills and activities generally ascribed to his/her age and growth developmental levels. He/she needs assistance with self-held activities (dressing, eating, etc.) that the other children in his class can handle independently.	A child who exhibits significant gaps in functioning when compared with his/her peers in the classroom. Child needs some teacher assistance in most classroom activities and self-help skills.	A child who exhibits great difficulty in functioning in the pre-school classroom. His/her delays do not allow him/her to participate in many group activities with his/her peers. The child requires much individual assistance from the teacher and aide. He/she can participate independently in very few activities. (Head Start probably enrolls very few of these types of children).	A child with this extreme level of involvement will not be found in a Head Start classroom. This level of disability requires home-bound educational programming. Children who fall into this category usually are totally dependent upon adult care. They cannot control bodily functions and have extremely limited abilities related to developing any self-help skills.